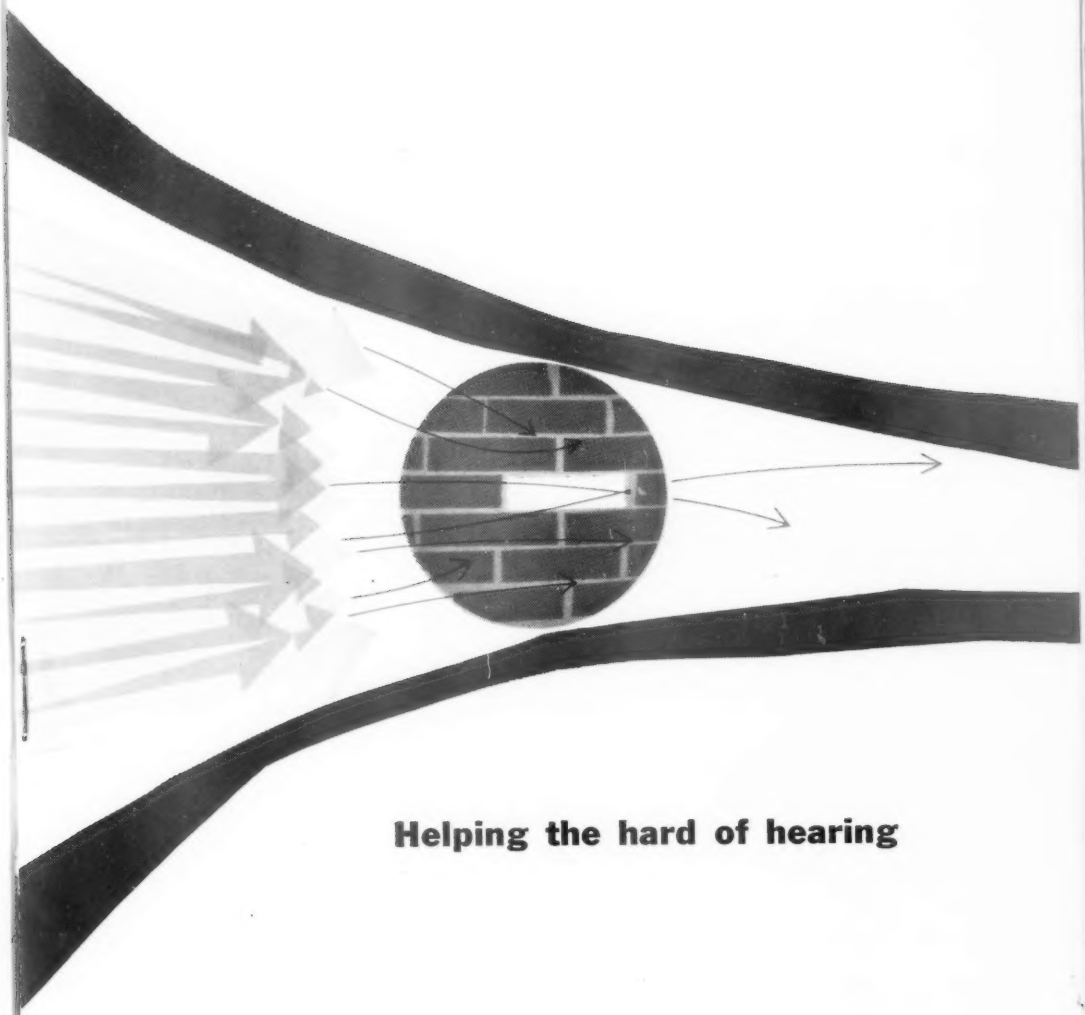
RN

OCTOBER 1961



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MORE▶

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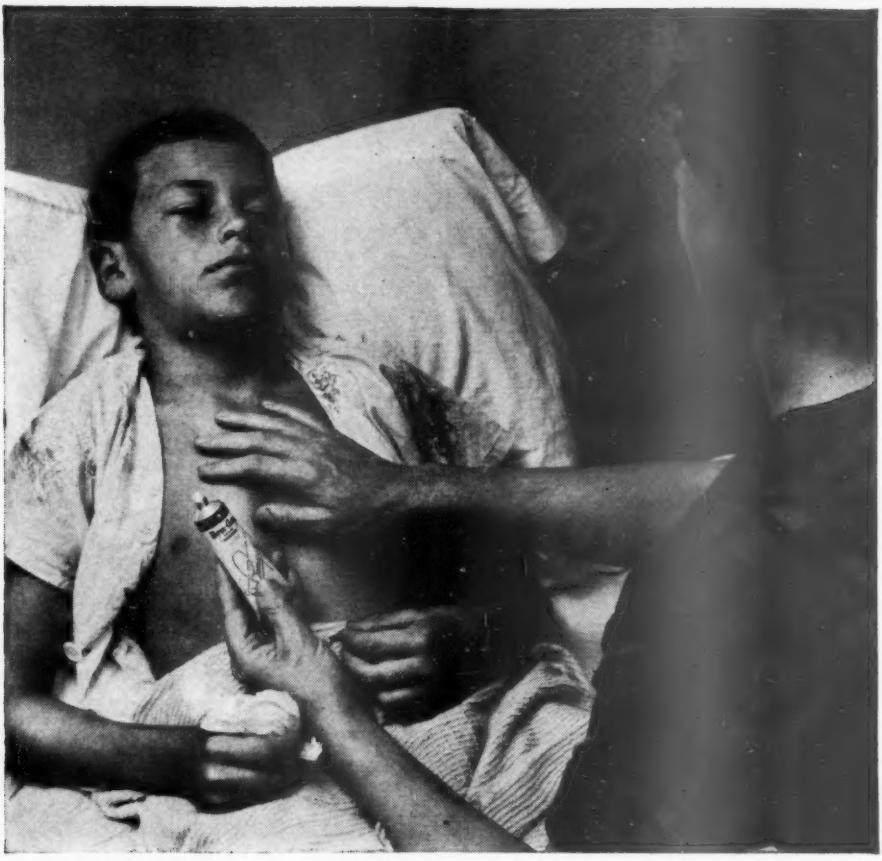

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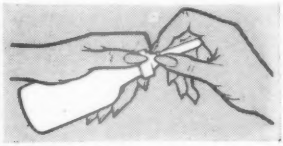

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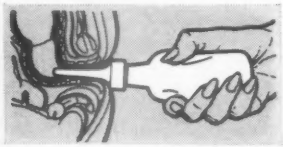

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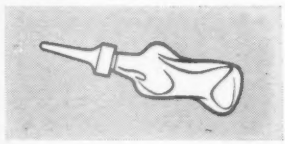

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Reference: 1. Hardy, James D.: The Nature of Pain: J. of Chronic Diseases, Vol. 4, July 1956.

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RN letters

WHEN THE EGG HITS . . .

DEAR EDITOR: I howled with glee as I read Beverly T. Duffin's recent article. "You're Asking *Me?*" I, too, used to give parents advice on child-raising before I had children of my own. Now, as I think back, I hope the parents weren't dumb enough to take my advice; if they were, I'm probably responsible for a whole herd of youngsters with mental quirks!

By way of being completely comforting to Mrs. Duffin, let me say this to her: "Wait till your two little cupcakes are teen-agers; that's when the egg really hits the fan!"

Eileen M. McLaughlin, R.N.
Kings Park, N.Y.

COMEBACK PLAN

DEAR EDITOR: I can understand why a nurse who hasn't donned a uniform for many years may feel chicken-hearted about resuming full-time hospital work. I myself was scared green at the thought.

But kind fate led me to the office of an understanding nursing director. Together we worked out an experimental arrangement: a four-hour day that would ease me back into hospital routine while giving me continuity of patient-care.

The plan worked well. True, I felt like a shadow following nurses about to see what they were doing and how they were doing it. I asked, asked, asked—and was always answered cheerfully. Everyone from charge nurse to ward maid was helpful.

The half-time work gave me (and my feet!) a chance to reaccustom myself to bedside nursing. In a month I was ready for full-time duty.

I'm sure a similar plan at other hospitals would encourage many hesitant R.N.s to make a comeback.

Marion B. Sudnow, R.N.
Miami, Fla.

DEGREES FOR OLDER R.N.s?

DEAR EDITOR: Degree nurses are undoubtedly helping to raise our professional standards; but I hope we haven't forgotten that many older nurses have also helped to pave the way to better nursing.

So how about degree recognition for long and faithful service? Twenty-five years in, say, public

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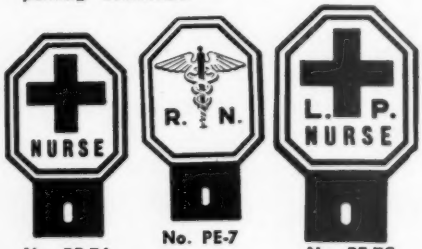

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...letters

health nursing may or may not be the equivalent of a college education; but why not grant *honorary* degrees to some deserving older nurses?

Mable Jones, R.N.
Lehi, Utah

UNDUE FAMILIARITY

DEAR EDITOR: Maybe I'm old-fashioned, *but:* I don't care for the use of first names between doctor and nurse in the patient's presence. It's poor practice because it tends to lower their professional dignity.

Leah A. Brogan, R.N.
New York, N.Y.

POESY'S EFFECT

DEAR EDITOR: Thanks to Margaret Berger for the poem, "Spring, 1 Minim," in the May issue of *RN*. As I set up my medicines today I found a new challenge in this routine chore.

Mildred Merrick, R.N.
Redding, Calif.

WHAT WE TRY TO HIDE

DEAR EDITOR: I constantly marvel at your staff's sensitivity to our individual problems. A case in point: your last month's article on the care of a relative with terminal illness. This particular problem is one that every R.N. must be prepared to face, sooner or later.

I've already had that experience: I nursed a sister whom I loved dearly. She had terminal

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1. The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953. 2. Brown, G. W.; Tuholski, J. M.; Sauer, L. W.; Minsk, L. D., and Rosenstern, I.: J. Pediat. *56*:391 (Mar.) 1960.

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cancer. I took a two-month leave of absence to care for her in our family home. After the funeral, I said "Never again!" And I've made this clear to my aging parents.

Your article puts into writing what many of us try—for ethical reasons—to hide: our true feelings, our innermost thoughts, our guilt, our divine satisfactions. Bravo!

Evelyn Moore, R.N.
Pittsburgh, Pa.

ECONOMIC SECURITY DRIVE

DEAR EDITOR: As spokesman for seven R.N.s at the Holyoke (Mass.) Hospital, I thank you for your recent article about the economic security drive in Orange County, Calif. This stimulating story has given us the courage to take similar action to remedy a similar situation.

We realize that we may have a long struggle ahead of us, but we believe now is the time to act.

Sonja L. Fisher, R.N.
South Hadley, Mass.

DEAR EDITOR: . . . Here's one reason why the economic security program lacks widespread public support: Because hospital rates are high, many people think

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...letters

that nurses' salaries are high too!

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Constance McClun, R.N.
Payette, Idaho

OUGHT TO BE A LAW?

DEAR EDITOR: There ought to be a law requiring older nurses who haven't practiced for ten years or more to take a refresher before resuming active duty. Without refresher training some, for example, may not realize how important it is to get post-op patients up and moving around; others, how dangerous it is to give treatments without doctors' orders.

Another point: If more refreshers were available, more of the older graduates might return to nursing. We could all benefit by the exceptional care such nurses are capable of giving.

Alvina Lee, R.N.
Ada, Minn.

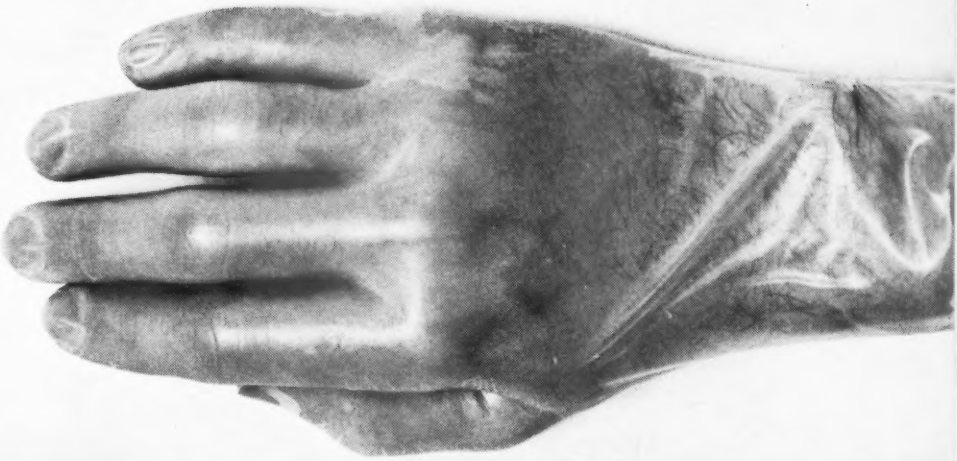
HARMFUL THINKING

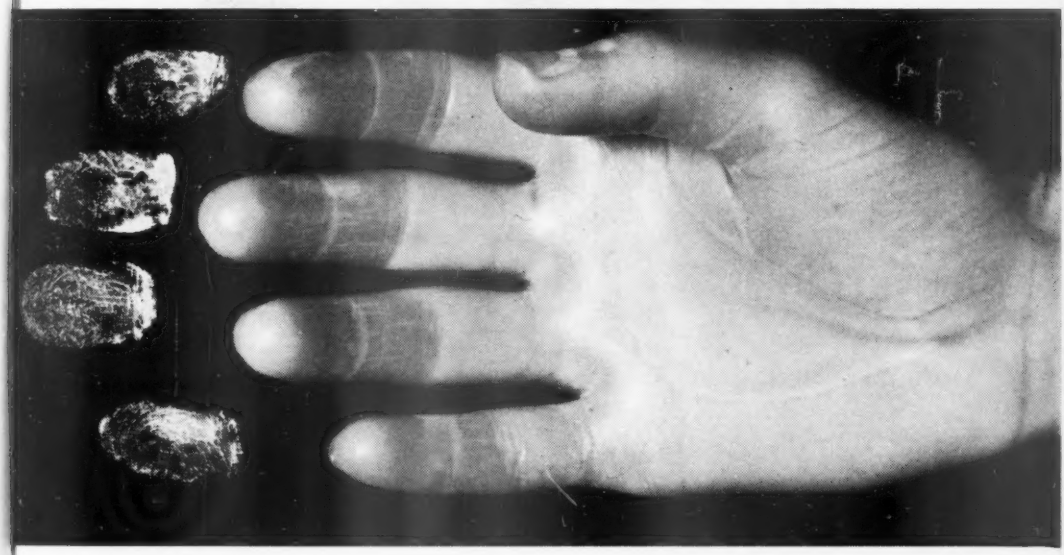
DEAR EDITOR: No two patients are alike, no matter how similar their ailments may be. Yet some nurses say, "When you've seen one case like this, you've seen 'em all!"

I object to this kind of thinking. It tends to make nurses as cold toward their patients as assembly-line workers are toward mass-produced burlap bags.

Nothing can take the place of T.L.C.!

Betty Jane Mackey, R.N.
Globe, Ariz.





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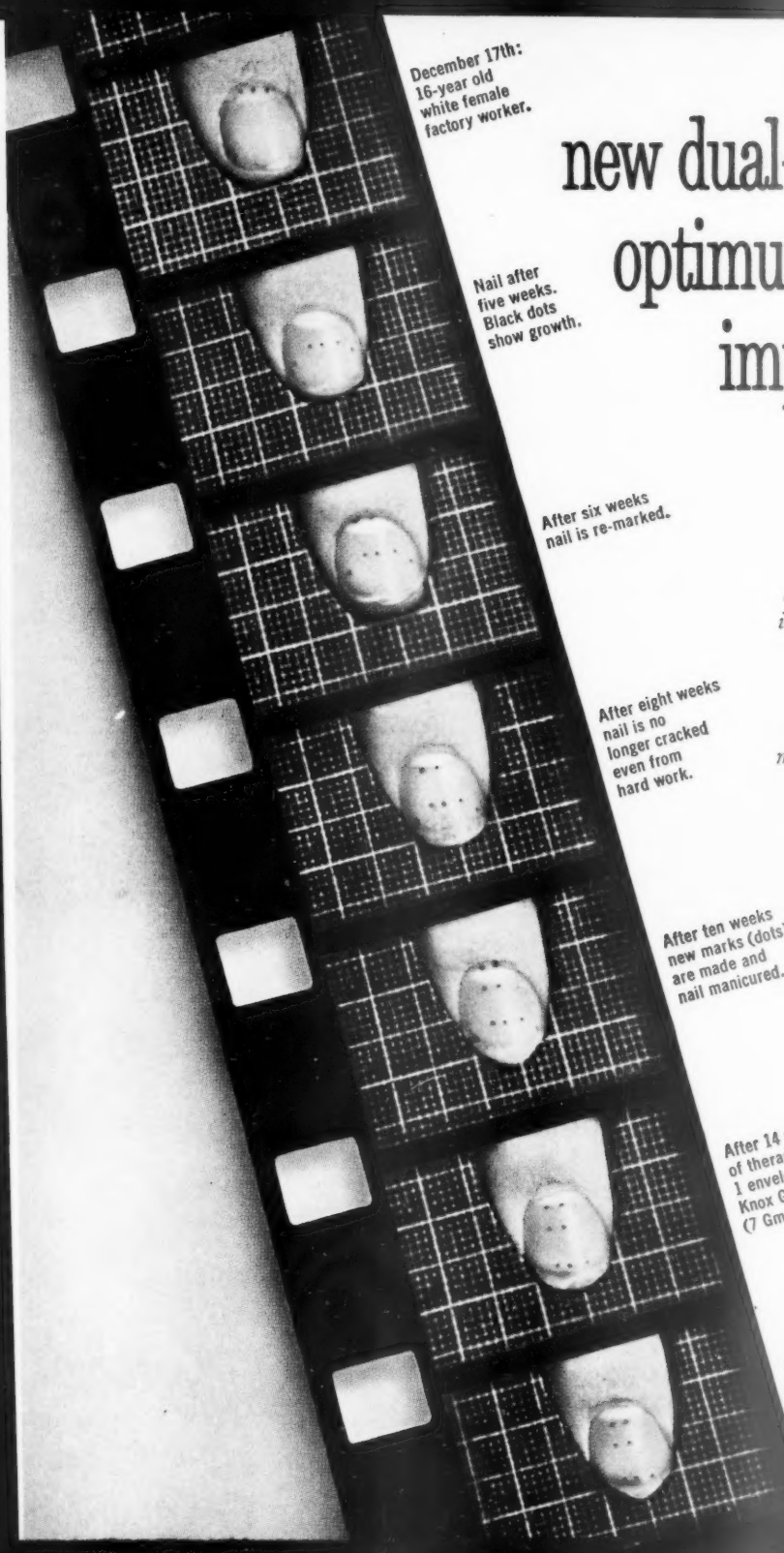

new dual-control optimum dose improving

Actual clinical photographs. Time-lapsed 8mm color cinematography illustrates response of brittle fingernails to Knox Gelatine therapy. At end of period patient could manicure strengthened nails to full point. Film courtesy of Dr. Kurt A. Oster.

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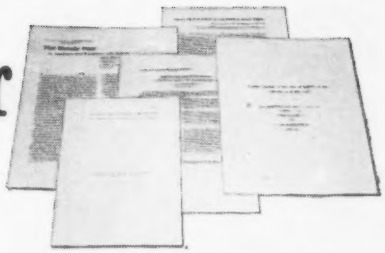
study[1] establishes of Knox Gelatine for brittle fingernails



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- ☐ 1. Derzavis, J.L. and Mulinos, M.G.: Med. Ann. D.C. XXX:133, March, 1961.
- ☐ 2. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September, 1957.
- ☐ 3. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July, 1957.
- ☐ 4. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March, 1955.
- ☐ 5. Tyson, T.L.: J. Invest. Dermat. 14:323, May, 1950.

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RN11

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RN news

A.N.A. says doctors are pressuring R.N.s

Are local doctors pressuring you to disavow the A.N.A.'s stand favoring health care for the aged through the Social Security program?

They're doing this in many communities, charged an A.N.A. spokesman at recent House Ways and Means Committee hearings on the Anderson-King bill. But nurses are resisting, she said. They "believe firmly in the position taken by their [national] professional association."

Opposing views on collective bargaining

Collective bargaining for R.N.s still lacks the unanimous support of organized nursing. In a recent policy statement, the American Association of Industrial Nurses opposes such bargaining for industrial nurses, charging that it would "jeopardize the [industrial] nurse's position both with management and labor."

The American Nurses' Association's Occupational Health Section disagrees. In answer to questions on the A.N.A. Economic Security Program, raised by its members, the Section points out that industrial nurses share with all nurses the need for adequate salary, good working conditions, and security. Economic gains achieved through collective bargaining will, the Section says, "elevate the status of nursing . . . and assure that qualified persons will enter and stay in the field."

'Low-fat diets may raise blood-fat levels'

A diet rich in sugars and starches tends to raise the levels of one of the major fats in the blood. So, to reduce these levels (and thus possibly combat atherosclerosis), it may be wise to reduce the intake of carbohydrates and increase the intake of liquid fats.

That's the gist of a study team's findings as reported to the Association of American Physicians by Dr. Edward H. Ahrens of the Rockefeller Institute. The study indicates that:

¶ Blood triglycerides, the chief constituent of fatty tissue, may be as important as blood cholesterol in causing circulatory disorders.

¶ The levels of blood triglycer-

ides are highest when a no-fat diet is prescribed, lowest when the diet contains 70 per cent fat.

¶ These triglyceride levels don't vary much whether a person's dietary fats are saturated (as in dairy products) or unsaturated (as in vegetable oils). But it's still true that blood cholesterol levels are much lower when dietary fats are unsaturated.

Part-timers increasing, says Women's Bureau

The number of women working part-time is increasing faster than the number working full-time, the Women's Bureau of the Department of Labor reports. The bureau quotes two studies that indicate 30 to 40 per cent of general duty nurses are part-timers. In all fields, women part-timers are expected to increase 50 per cent by 1975 to a total of 9,000,000.

M.D.s predict additional nurse-specialization

Within twenty-five years nurses will be closing wounds in routine surgery. Several doctors predicted this recently at an A.M.A.-sponsored conference on the medico-legal implications of delegating more responsibility to R.N.s. Said one M.D.: "Nursing is likely to

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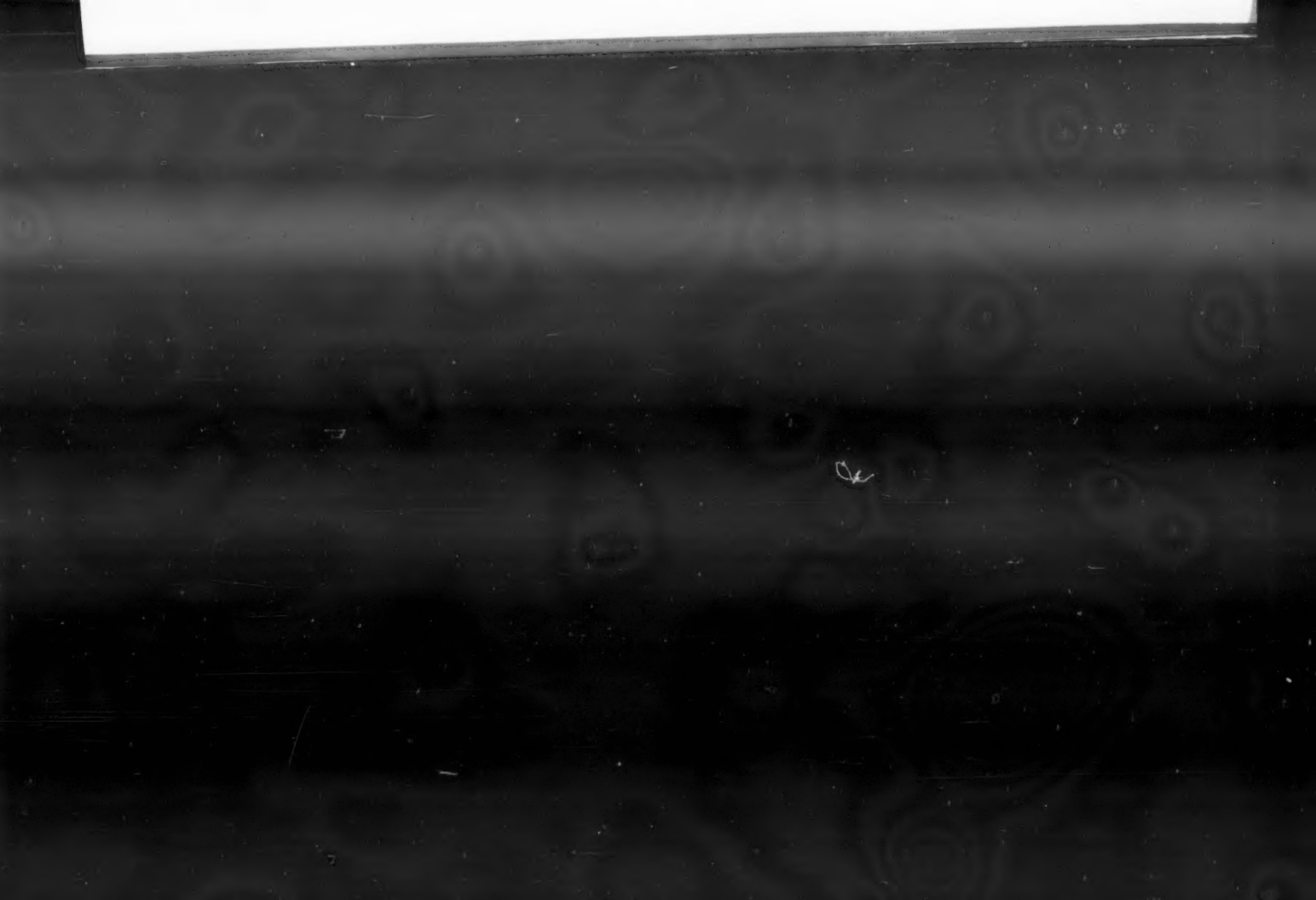

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*Bogash, R. C.; DeLa Chapelle, N.; Sowinski, R.; and Downes, D.: Disposable Type Vials for Adding Medications to Large Volume Parenterals, Am. J. Hosp. Pharm. 17:104 (Feb.) 1960.

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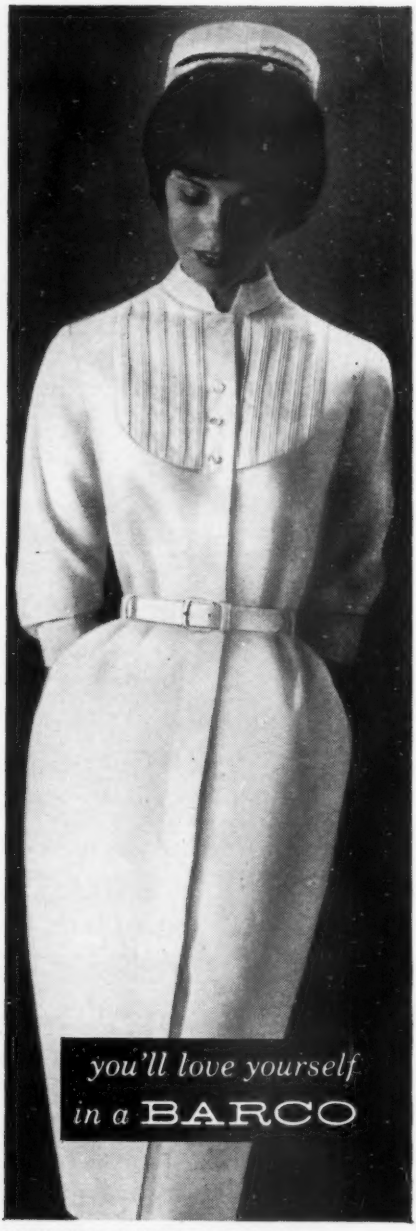

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become as specialized in its training and performance as medicine is."

Present state laws limiting nursing practice will not have to be modified to accommodate R.N.s' new responsibilities, an attorney assured the doctors. The new techniques nurses perform will gradually be accepted through "custom and usage."

One in six is discharged too soon or too late

Two-thirds as many hospital patients are discharged too soon as are kept in the hospital too long, Michigan researchers find. Their figures, based on a state-wide study of some 11,000 discharges, show that understays run 6.8 per cent, overstays 9.6 per cent, total 16.4 per cent (one in six). Other findings:

¶ Though most patients surveyed needed to be hospitalized, about two in every 100 didn't.

¶ Nearly a third didn't get all the diagnostic/therapeutic procedures their conditions warranted.

Doctor calls football too rough for youngsters

Misguided people who organize football leagues for 8- to 14-year-olds are doing more harm than good. Football is probably the least beneficial sport for such youngsters and certainly one of the most hazardous.

So contends Dr. Robert A. Mc-

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Guigan of Northwestern University, writing in the Archives of Pediatrics. He cites recent insurance-company reports indicating that:

¶ Football causes half the injuries among junior high school athletes.

¶ The younger the player, the more likely he is to be hurt. The incidence of injury among younger athletes is five times that for 18-year-olds.

In the doctor's home state—Illinois—and in several other states, the state medical societies are urging elementary and junior high schools to ban football, boxing, and other body-contact sports.

New gastroscope enables M.D. to scan duodenum

A new flexible gastroscope that can be worked past the pyloric sphincter into the upper intestine makes it possible to detect duodenal ulcers by direct visual examination, says Dr. John H. Hett of American Cystoscope Makers, Inc., Pelham Manor, N.Y., in a report to the Optical Society of America. The procedure can be done in the doctor's office.

The device makes use of "fiber optics," a new principle of image transmission, Dr. Hett explains. Light travels through the scanner via coated glass fibers that are formed into a flexible tube. Similar devices are expected to be developed for other diagnostic work, including visual examination of the heart's interior.

Recovery-room personnel warned of hazard

If you work in a recovery room or other post-op unit, don't underestimate the danger of an anesthetic-caused explosion.

This, in effect, is the warning given in a report to the A.M.A. by Drs. Beatriz L. deNava and Thomas F. McDermott of Georgetown University. Anesthetic gases, they found, may be retained postoperatively in the stomach for periods ranging from twenty-five minutes to four hours. If vomited or eructated, they're flammable.

The doctors cite one case in which anesthetic gases from a patient ignited two and a half hours after surgery.

Ultrasonic waves used in place of X-ray

A new diagnostic device called a soniscope is undergoing clinical trials in the Chicago area. It uses ultra-high-frequency sound waves to confirm suspected fractures and to check on the healing of other fractures. Both procedures now require X-ray.

To confirm a fracture in, say,

Continued on page 100

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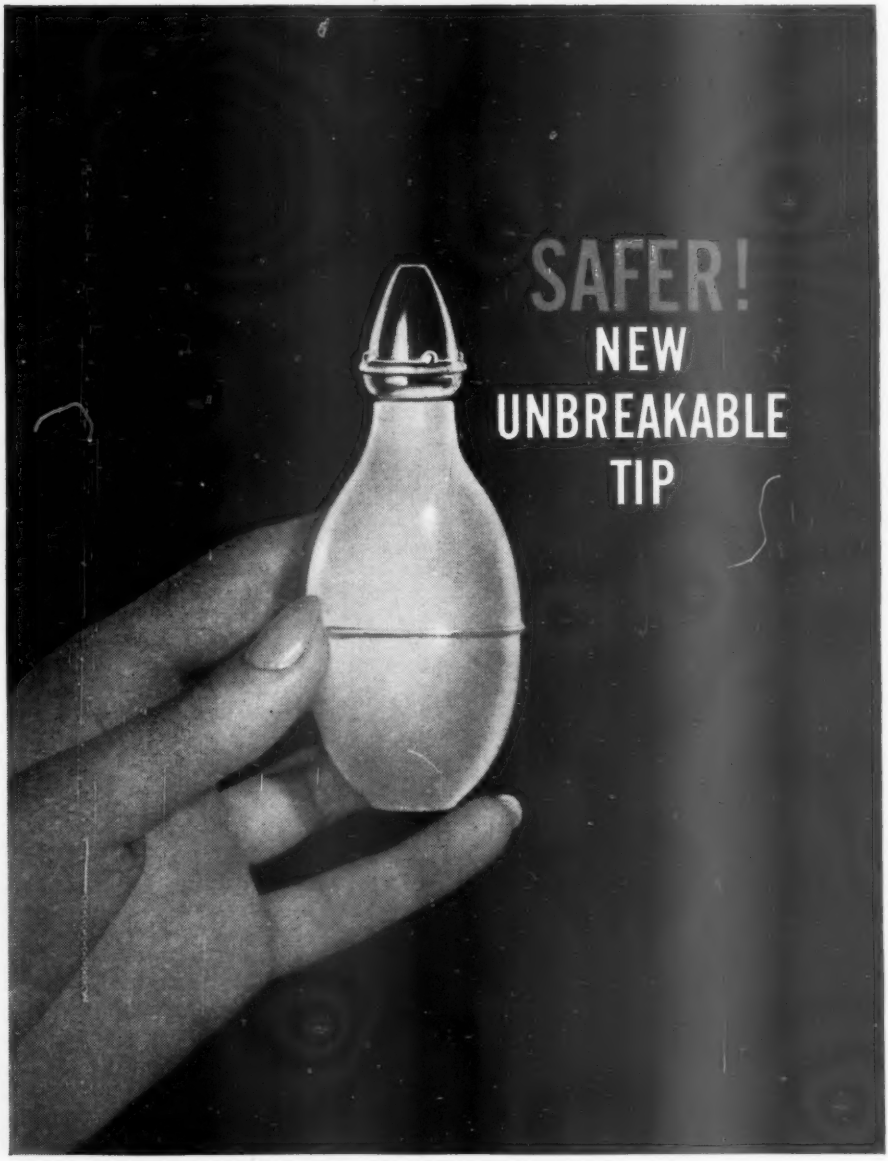

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RN

literature and samples

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CLEANSER: A new cleansing compound for surgical instruments and glassware is Super Edisonite. High cleansing efficiency, mildness, and rapid dissolution are described and supported by laboratory evidence in a circular. Also provided is a three-ounce sample of Super Edisonite. Edison Chemical Company, Inc. **K-2**

STERILE-PACKED SURGICAL FILM: Vi-Drape Surgical Film is now available in presterilized, sealed rolls, ready for immediate operating room use. The original Vi-Drape, for autoclaving before use, is also retained. Clinical literature and information on motion picture scheduling are offered to O.R. personnel. Aeroplast Corporation. **K-3**

FERTILE PHASE: How to determine dates within the cycle when conception is most likely to occur is the purpose of the Fertility Testor. Literature. Weston Laboratories. **K-4**

UNIFORM STYLES: A booklet contains twelve exciting pages of the season's newest in a variety of fabrics, sizes and sleeve lengths. Bob Evans. **K-5**

NUTRITIOUS OATMEAL: "Why Oatmeal Is Naturally Nutritious" is the title of a booklet which presents a scholarly report in attractive and easily-read form. Interesting to all nurses who have any responsibility for diets. The Quaker Oats Company. **K-6**

TO MOVE PATIENTS SAFELY: Stretcher-Grip is the name of a device which securely locks bed and stretcher toegther for safer and easier transfer of patients. Literature. Stretcher-Grip Company. **K-7**

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1. Paul, W. D.: Rehabilitation in Rheumatoid Arthritis, South. M.J. 53:492, (April) 1960
2. Tebrock, H.H.: Ind. Med. & Surg. 20:480, 1951

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RN

The child with diabetes

By Charlotte Isler, R.N.

About one of every 2,500 children under 15 years of age has juvenile diabetes. Suppose you are asked about this disease. Is it the same as adult diabetes? How is it treated? How do children respond to treatment?

Parents of diabetic children may ask you these and other questions. Here are some answers, with pointers that will help you in your contacts with these children and their families.

Diabetes in a child, unlike that in an adult, is nearly always severe. The onset may be relatively sudden; but the disease doesn't develop fully for some time after diagnosis. Although the exact causes aren't known, it's believed that heredity is usually responsible.

Once the diagnosis is made, it's desirable to hospitalize the child for twenty to thirty days, even though his diabetes seems mild at first. This is because continued medical and nursing supervision are needed to control and stabilize the disease and because the child and his family need to be taught principles of management.

Three things are necessary for control and stabilization: insulin, diet, and appropriate physical activity. When these are provided in proper balance, the urine becomes sugar-free. At the same time, hypoglycemia (insulin shock) may be avoided.

At first, the insulin dose is adjusted daily. Within a week the

patient usually improves, as shown by a decreased insulin requirement. From this point on, insulin is gradually reduced until a steady, daily dose is established. This keeps the child free of glycosuria while allowing him to carry on normal activities and to enjoy a suitable diet. Once this stage is reached, he's ready to go home.

The days immediately before discharge can be trying ones for child and parents. Even after careful teaching, they may dread the experience that lies ahead. Knowing this, the nurse gives them maximum support and understanding.

At home, daily insulin injections are continued. If the child is very young, the parents give them. If he's older, he probably injects himself. (Children as young as six years often are able to do this.)

The child is encouraged, but never forced, to give himself injections. Practicing injections with an orange helps him to develop self-confidence. Frequently, he realizes that he feels better because of the injections; so he willingly gives them to himself. In such case, the parents see to it that he varies the injection locations to prevent tissue injury and possible cosmetic defect. (Children are apt to use favorite areas for repeated injections.)

He also is taught to check his urine three to four times a day, before each meal. If he's very young, or if he rebels, the parents may do this. In either case, commercial test strips or tablets are used to make the testing easy. If the child does the testing, the family is cautioned to check the results occasionally—especially if they are consistently negative. For the youngster may try to show how well he is by "testing" water.

For a time, the diet seems confusing to the mother. The doctor prescribes it according to the child's age and body weight. For instance, a 2-year-old is allowed 80 to 100 calories daily per kilogram of body weight; a 10-year-old is allowed about 55 calories per kilogram. The nurse helps the mother interpret the diet, which may be given in terms of exchange units (see

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THIS ARTICLE *was prepared with the help of Dr. John M. Brush, Associate in Pediatrics of Babies Hospital, Columbia Presbyterian Medical Center, New York City. It's the final article of three on diabetes. The first (May, 1961) concerned adult-diabetic care. The second (June, 1961) discussed drugs for diabetes treatment.*

food-exchange meal plan, page 39).

Getting the diabetic child to eat is seldom a problem. Usually, he wants more than his diet allows. The nurse can teach the mother how to make substitutions. She can explain that many dietetic foods are available commercially, including noncaloric soft drinks and sweeteners. These must be checked for their exact food value; then they can be used to brighten a meal. (Intake of the soft drinks should be controlled by the parents.)

Suppose the child is asked to a party: Does he have to refuse sweets? Definitely not. The mother can plan ahead. For example, she can omit a slice of bread and two pats of butter from the day's diet; then the child can enjoy a dish of vanilla ice cream at the party.

While at school, the child

DIABETIC YOUNGSTERS *at Michigan Diabetes Association-sponsored Camp Midicha, Columbiaville, Mich., enjoy day's end around the campfire. The camp accommodates 80 children for two-week periods.*

EATING TIME'S *a happy time at Uni-Betic Camp, San Bernardino County, Calif. Foods are weighed and/or measured according to the individual camper's need. Sponsor: Los Angeles County Metabolic Clinic, Inc.*

may need between-meals snacks to help avoid insulin shock. He carries his own special lunch each day. The school nurse knows of his condition, so she keeps tabs on him. For instance:

She encourages him to carry a card or wear a bracelet that identifies him as a diabetic, in case of insulin shock or diabetic coma. She asks him to carry a lump or two of sugar with him and makes sure he knows he should eat a lump at once if insulin shock starts. She also encourages him to engage in all activities his classmates enjoy so he won't feel apart from them. She reassures the family from time to time.

When special events are scheduled that will keep the child at school beyond his usual hours, she notifies the mother ahead of time. For example, suppose a school picnic is coming up. She tells the mother, who then plans the day's diet accordingly. The mother cautions the youngster to eat his picnic

The food-exchange meal plan

A diabetic's diet may be written in terms of the quantity of a food (for example, 1 slice bread, 1 oz. meat). But many doctors today use the food-exchange plan. They specify exchange units, as in this sample dinner:

Food	Meat	Vegetable	Bread	Fruit	Milk	Fat
Units	2	1	2	1	¾	3

To convert these units, the patient consults exchange lists. Each list names a variety of foods that have equal food values. For instance, the above dinner for a 10-year-old diabetic child could include any one of several selections for each item, as listed in the booklet "Meal Planning with Exchange Lists." * Here are two examples:

First dinner	Alternate dinner
5 boiled shrimp	1 oz. roast beef
½ cup carrots	½ cup squash
2 slices corn bread	2 muffins
1 cup strawberries	1 medium peach
¾ cup whole milk	¾ cup skim milk
6 tbsp. light cream	3 small pats butter

*Available from the American Diabetes Association, Inc., 1 E. Forty-fifth Street, New York 17, N.Y.

meal at about the same hour he normally would eat and to be home in time for his usual evening meal. If this isn't possible, she provides him with snacks to tide him over.

As the child's ailment progresses to total diabetes, several problems come up. Within three years his insulin need may rise from, say, ten units daily to

Continued on page 88

Warn your arthritis patients against these quack cures!

Arthritics are easy prey for the purveyors of false hope. Here's what you can do to help stop this swindle

By Edith S. Oshin

As you read this, thousands of sufferers from arthritis and rheumatism are hopefully trying "new discoveries" for the "cure" of arthritis that they've read about in circulars and ads.

Thousands of others are using weird gadgets they bought at outlandish prices (see photos). Still others are taking "treatments" at hot springs, "electrotherapy" centers, and other "clinics" that promise them quick relief—or an outright cure. (Some sufferers visit "uranium" mines and sit in the tunnels at $10 a visit.)

FACTS IN THIS ARTICLE *come from the book "The Misrepresentation of Arthritis Drugs and Devices in the United States," by Research Consultant Ruth Walrad, published by The Arthritis and Rheumatism Foundation, New York City.*

Each year an estimated half of the nation's 11,000,000 arthritics pour out $252,000,000 on such products and treatments that are, at best, overpriced and misrepresented. At worst, they are harmful or dangerous.

Why are arthritics such easy prey for the quacks?

There are three reasons, says The Arthritis and Rheumatism Foundation: First, arthritis is often agonizing. Even in its mildest forms, it's frightening. The sufferers know of others who are crippled by the disease. They fear their condition will worsen.

Second, medical science has no cure for arthritis. Though it can *control* the disease, treat-

BIZARRE PRODUCTS *such as this "vrilium" tube are dreamed up by the unscrupulous who promote them as cures for arthritis. Prices often depend only on the seller's power of persuasion. This brass container sold for $300. Its contents: barium chloride worth 1/2,000 of a cent. Its effect on the disease: none. The device is part of The Arthritis and Rheumatism Foundation's exhibit of quack cures that's now touring the country.*

ment is long and undramatic. Many sufferers become discouraged. They turn in desperation to anyone who promises them a fast, easy cure.

Finally, unlike most other diseases, arthritis has unexplained periods of remission. An arthritic may have had severe pain for months. Then suddenly he feels better. If he's trying a quack remedy at the time, he joyously credits the remedy for his "cure." (This is the source of many testimonials the swindlers use.)

There seems to be no limit to the kinds of products arthritics will buy. Influenced by the current "natural food" fad, some try alfalfa concoctions or lemon juice or sea water. Others are drawn to the old stand-bys of grandmother's day: poke berries, wild-cherry bark, dande-

lion root, et al. that "cleanse the blood of poisons."

"Glorified aspirin" is a favorite of many—and of the unscrupulous promoters who sell millions of dressed-up, fancifully named, overpriced pills each year. The aspirin in these products (usually in small amounts) is, of course, effective for pain relief. But the sellers make exaggerated claims on the basis of other "new" and worthless ingredients. The more they exaggerate, the more they charge for their product.

Vibrators are another best seller. These include pads, pillows, chairs, and tables—some claimed to produce "curative" ultrasonic vibrations. The Federal Government has ruled these gadgets can't be offered for anything more than temporary relief of arthritis and rheumatism. But scheming promoters skillfully dodge this restriction.

What can the medical profes-

PSEUDO SCIENCE *helps sell strange gadgets to arthritis and rheumatism patients. The manufacturer of this $30 "oxydonor" claimed it "reversed death process into life process." The victim was directed to clip the metal disk to his ankle and then put the cylinder into cold water. The colder the water, the faster the arthritis would go away, according to the circular with the gadget. Actually, it's completely worthless as a "cure" for anything.*

PUBLIC INTEREST IN URANIUM *has brought on a rash of "radiation" devices, including mitts and pads filled with dirt supposedly containing the ore. The seller of this "rado pad" claimed a cure with each $30 purchase. But the pad gives off no more radiation than the luminous dial of the watch the victim wears. Any more radiation than this would endanger the user. (If a new radiation treatment were beneficial, M.D.s would know before quacks.)*

sion—and specifically you, as a nurse—do to fight this cruel swindle?

First, you can help promote, through your professional organizations, effective laws and law enforcement against the swindlers.

Second—and this, points out The Arthritis and Rheumatism Foundation, is fundamental to defeating the racket—you can help educate the public (starting with relatives, neighbors, and friends) by warning them against quack products. You should also:

1. Tell arthritics, frankly, that years of careful medical research have shown that a "quick

DECORATIVE BUT NOT CURATIVE: *Two-dollar copper bracelets like this one sold for $15 to $30 a pair. When the sufferer wore such a bracelet on each arm, a "curative circuit" would be set up, the promoters claimed. Sales based on belief in quack magic are frequently made in big cities as well as in backwoods areas. Even an intelligent and well-informed arthritic is tempted to try such gadgets when he is desperate with pain.*

cure" for arthritis isn't yet possible. Reassure them by adding that advances are being made almost daily. Add that many effective drugs are now available for use by doctors, including gold compounds and the steroids. Emphasize that *none* of these drugs are included in the quack products.

2. Warn them that by buying and trying such products they lose something more valuable than their money: They lose *time*. Emphasize that early and continued treatment by a competent doctor is necessary if permanent damage is to be prevented. To illustrate, point out that in rheumatoid arthritis—

FANTASTIC AND POSSIBLY HARMFUL: *Instructions for using this "inducto-scope" advised that labels on the hoops must be on the inside to treat arthritis, facing each other for neuritis. The Food and Drug Administration seized the device. The Federal Trade Commission and the Post Office Department also fight quackery. But as soon as one product is forced off the market, promoters conjure up others. So the flow of quack products is constant.*

the most crippling form of this disease—severe crippling can be prevented in seven of ten cases *if* treatment is started in time.

3. Encourage the patient who's on exercises to continue them faithfully. Emphasize that they help keep his joints and muscles flexible. Point out that this will help him move about with less discomfort—especially during remissions.

4. Teach him effective ways of self-help. For instance, if he has trouble combing his hair, suggest using a long-handled comb. Learning new ways of getting along on his own will encourage him and make him less likely to try a quack product.

5. If he seems about to be taken in by the claims of a salesman (many promoters send salesmen to arthritics' homes), advise him to talk to his doctor before buying. Suggest that he write to The Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York City. The foundation will answer his questions about any specific product and will provide general information that will help him spot and avoid quack remedies and treatments. END

Bed and board

The doctor always ordered "Bed board under bed" for the orthopedic patient. One day, on impulse, we put a board under the patient's bed as well as one under his mattress. When the doctor came in, the head nurse asked innocently: "When may we remove the board so the floor can be cleaned?"

Eyes twinkling, the doctor wrote on the order sheet: "Board under mattress should remain in place. Board under bed may be removed. Its therapeutic efficacy has passed its peak." —EDITH S. TAYLOR, R.N.

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address: Anecdotes,* RN, *Oradell, N.J.*

Are contact lenses for you?

Here's what you need to know if you're thinking of joining the 6,000,000 Americans who now wear these tiny prostheses

By Martha Dudley, R.N.

Some women own contact lenses of various hues. By inserting an appropriate pair, they change the color of their eyes to match each ensemble they wear!

While this is carrying vanity to an extreme, there's no denying that most women who wear contact lenses do so for cosmetic reasons.

Perhaps you, or a member of your family, have been thinking you'd like to give contact lenses a try. But before you do, you'd like to know a little more about them.

These tiny, nearly invisible lenses* offer many advantages other than concealing the fact that the wearer's eyesight has to be corrected. For instance:

¶ They don't fog over as ordinary glasses often do.

¶ They give at least 15 per cent wider vision. (This can be especially helpful when you're driving.)

¶ They can be worn while you're taking part in vigorous sports (golfing, tennis) without

* Plastic corneal lenses are the type referred to throughout this article. They make up about 90 per cent of the contact lenses worn. Scleral lenses are larger, and are difficult to fit, to adjust, and to tolerate. They're now used only for special medical conditions and some sports.

danger of breaking or eye-injury.

¶ They may become scratched while off the eyes, but they seldom break. (Scratches may not affect their usefulness; for the fluid from the eye's natural tear layer fills the scratches and makes them unnoticeable.)

Contact lenses have been so improved that ophthalmologists now prescribe them for many specific eye conditions (see below). Sometimes they can help a patient dramatically. For example:

A 50-year-old woman had been nearly blind from a corneal condition for thirty-two years. (She had even been claiming an income tax deduction for blindness.) Contact lenses improved her sight so much she was able to go to work.

Not everyone, though, can wear "contacts." Many doctors discourage their use if a patient is nervous or has tremors or a severe allergy. And they don't help those who suffer presbyopia (impairment of near vision due to old age). Also, they're

Some conditions in which corneal contact lenses are used

Albinism (congenital absence of pigment)

Aniridia (absence of the iris), monocular or binocular

Anisometropia (difference in refractive power of the two eyes)

Aphakia (absence of the lens)

Corneal scarring

Exophoria (outward deviation of an eye when covered)

Hyperopia (far-sightedness)

Keratoconus (cone-shaped deformity of the cornea)

Myopia (near-sightedness)

Some corneal dystrophic conditions

Turned-in eyelashes

Vertical muscle imbalance

When the patient is allergic to materials in spectacle frames

contraindicated for a number of specific conditions (see below).

If you're wearing bifocals now, better forget the contacts. Some bifocal contacts have been made and worn, but with limited success. Too, some people have found it helpful to wear reading glasses *and* contact lenses. But in general, contacts are prescribed to correct distance vision or for special conditions. (Most ophthalmologists consider the early teens to the late thirties as the best years for starting to wear these lenses.)

Still interested? Then the next thing you'll want to know about is the cost. The lenses run from $150 to $300 a pair. They can —and should—be insured. On the bright side: They're usually good for five years or more. (Apparently they change the shape of the cornea slightly, thus decreasing the number of changes necessary. Whether or not this is a permanent change hasn't been determined.)

Let's suppose you've decided to get a pair of contacts. The first thing you'll want to do is

Some contraindications for corneal contact lenses

Allergic or chronic blepharo-conjunctivitis (inflammation of lid conjunctiva often caused by staphylococcus)

Corneal degeneration, dystrophy, edema, erosion, infection, inflammation, insensitivity

Epiphora (abnormal tear overflow)

Severe exophthalamus (protruding eyeball)

Angle closure or simple glaucoma

Iritis (inflammation of the iris)

Chronic infection of the lid or thick or tight lid

Local neoplasm

Pemphigus (a blistering that leaves scarred areas)

Pterygium (a growth from the conjunctiva onto the cornea)

Sjögren's syndrome (dryness of the mucous membranes)

consult an ophthalmologist. M.D.s warn that lenses must be fitted expertly. Poorly fitted ones, they say, are a potential source of corneal abrasion and disease. Though abrasion is self-limiting, it's painful. If the abrasion becomes infected, it can affect the vision and may injure the eye permanently.

Now, suppose you've selected your doctor and told him you're interested in contact lenses. He examines your eyes to make sure you don't show any contraindications. Then he helps you decide whether or not your motivation is strong enough to carry you through the period of adjustment ahead.

He explains that today's plastic lenses are tiny: Only one-third inch in diameter and 6/1,000 of an inch thick. They cover 60 per cent of each cornea. When properly fitted, they "float" on the fluid layer of tears that covers the eyeball and are held firmly in place by capillary attraction and the upper lid. But no matter how perfectly they fit, they always touch the cornea at one or more points. So it will take time for your eyes—and you—to get used to them.

Next, he writes your prescription. Five to ten days later, he tells you your lenses are ready. You go to his office for the fitting. (You'll visit him again many times during the coming months.) He inserts the lenses and checks them. If they seem to fit properly, he asks you to wear them for three to five hours, then return to the office. At the end of that time, he checks them again. If they're satisfactory, he teaches you how to remove and to reinsert them. He explains the importance of cleanliness in handling the lenses. He emphasizes points such as these:

¶ Wash your hands in soap and water and rinse them well before insertion and removal.

¶ When the lenses aren't in use, keep them in their special box or in a special soaking solution.

¶ If you get grease, oil, or cosmetics on them, clean them with lighter fluid, benzene, half-strength household detergent, or 70 per cent alcohol, wash with soap and water, then soak them in their solution for several hours before reinsertion.

¶ Don't wet them with saliva, for this can cause contamination.

Finally, he tells you to wear your lenses for three to five hours a day. He tells you that in a month, approximately, you should be able to tolerate them for eight to sixteen hours daily. (It's estimated that half of all contact-lens owners wear their lenses throughout their waking hours.)

He warns you that this first month is crucial. It will help you

Rescuing the victim of electric shock

Suppose you find a man lying unconscious across fallen wires, indoors or out, not breathing. Or, suppose you find him in another situation which indicates he has suffered electric shock. How do you help him?

If he's lying across wires indoors, turn off the current. If he's across wires outdoors, do this:

Use a *dry* board, tree branch, rope, or coat to move the wires or the victim or both. If the ground is wet, wear rubbers or stand on a dry board or a dry mat (from a car, for instance) as you work.

When contact with the wires is broken, position the victim face up, head back. Remove any foreign matter from his mouth and start mouth-to-nose resuscitation.*

After several lung inflations, check for the pulse. If there is none, start closed-chest cardiac massage. Alternate massage and lung inflation, checking the pulse occasionally. If the heart starts, discontinue massage but continue resuscitation until the victim starts breathing, or for at least four hours. (In one case of electric shock, breathing started after eight hours.)

If you're alone with the victim, don't delay the rescue-breathing to call a doctor. If you're not alone, send for a doctor as soon as the victim is freed. END

* See "The Nurse's Guide to Rescue Breathing," *RN*, August, 1960, and "Closed-Chest Massage Used to Restore Heartbeat," *RN*, October, 1960.

make a satisfactory adjustment, he says, if you keep these facts in mind:

1. You'll think of the lenses at first as foreign bodies in your eyes. And of course they are—just as dentures are foreign bodies in the mouth. So you need to develop a tolerance for them.

2. You'll have periods when your eyes will blink and become red and teary. You won't be able to open them wide and you'll have curious visual symptoms, such as colored rings and blurring. These are normal adaptive symptoms, common to all contact-wearers at first. To overcome them, you'll wear your lenses resolutely for the allotted time each day, increasing the time gradually under your doctor's supervision. (Unless you continue to wear the contacts regularly, your eyes will trouble you whenever you put them on.)

3. If you think about your lenses all the time, you'll be uncomfortably aware of them. This will be true even after your eyes have adapted to the contacts. The trick is to put them on each morning and forget about them.

4. You'll always have occasional bad days, just as denture wearers do. Your eyes may react because of illness (a bad cold, for example), lack of sleep, nervous strain, menstruation, or for no apparent reason. The important thing to remember is this: Like other ills, these periods will pass. You won't remember them after they're gone—especially when you look in the mirror at the alert R.N. who no longer wears spectacles! END

Head hunter

A school nurse inspected a fidgety first-grade boy for pediculosis and evidence of vaccination. When he went home he told his mother in disgust: "She sure was stupid. She looked all over my head for my vaccination before she found it on my arm."

—BARBARA HARTMAN, R.N.

Newest nurse-saver:

'Automated' drug administration

Two special pieces of equipment, a few special supplies, and some simple forms are helping R.N.s at York (Pa.) Hospital to

Reduce medication errors to a new low;

Spend more time in direct patient-care because they now need to spend less time pouring, administering, and charting medications;

Obtain drugs around the clock without special trips to the pharmacy;

Avoid the inconvenience of having nurses from other floors "borrow" drugs that are temporarily out of stock at other nursing stations;

Cut down on waste caused by spillage and by outdated drugs that often are kept on the shelves without rotation until they are unusable; and

Keep drug-charge records accurate and up to date with a minimum of frustrating paper work.

A new "automated" system of storing, dispensing, and accounting for drugs makes all the above possible. It's called the Brewer System. On the following pages you'll see just how it works. Then you'll understand why the staff at York Hospital heralds it as a real nurse-saver.

When the Brewer System is

The Brewer System is a development of the Brewer Pharmacal Engineering Corp., Upper Darby, Pa.

used, the pharmacist (not the nurse) is responsible for stocking the medicines kept at each "drug station"—as one of the system's two specially designed units is called.

In photo 1 (below), the pharmacist has opened the station. (Only he has a key to the upper section.) He's filling the bins with boxed and labeled drugs prepared beforehand in the pharmacy. The labeled drugs match "drug plates" that appear on a selection panel (closed in this photo). The bins hold up to 768 boxes—eight boxes each of ninety-six different drugs or various doses of fewer drugs.

Now the station is ready (photo 2, opposite page) and Daune Sitler, R.N., is making use of it. She has unlocked the cover of the drug-selection panel and has raised it so that a list of available drugs (with doses) appears above the panel. (The key to the cover is kept in the nurses' station.)

She is selecting a drug plate. If she removes more than one

plate at a time or returns a plate to the wrong slot, a warning alarm will sound.

To get the drug (photo 3), Mrs. Sitler sets up an imprinting shuttle. In it she places (1) the drug plate, (2) a charge plate for the patient, and (3) her own "key"—a plate with her identification number on it.

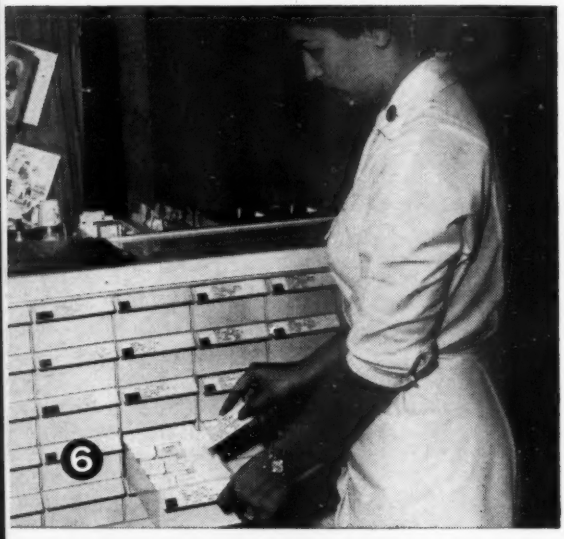
She places a charge-label form in duplicate (left hand) over the plates. Next, she'll push in the imprinting shuttle, touch a button, and the station will whir into action.

When the boxed drug appears in the slot (photo 4), Mrs. Sitler reaches for it. In her left hand she holds a label she has detached from the printed charge-label form in duplicate. It shows the patient's name, the name and dose of the drug, and the nurse's number.

Before leaving the station, Mrs. Sitler will compare the name and dose of the drug on the label with that on the box. She'll slip the original label under the clear plastic cover of the box and put the duplicate of the complete charge-label form in a bin for pick-up by the accounting department. (The machine makes a permanent rec-

ord of each drug transaction on tape.)

Now the Brewer "drug cart" (photo 5) goes into action as Mrs. Sitler starts on rounds. Each of the drawers visible on the side of the cart is marked with a patient's name and contains the patient's medications. Large drawers at the bottom hold liquid and stock medications, supplies, and records. A narcotics drawer has its own lock. All other drawers are locked by a single handle. (The nurse keeps the key.)



Before selecting the needed medication from this patient's drawer (photo 6), Mrs. Sitler returns the charge plate to the drawer. (The patient's plate is kept here so the nurse can charge medications while she's stocking the cart before rounds.) Note that medication boxes fit into the drawer so that each label is clearly visible.

After selecting the medication (photo 7), Mrs. Sitler checks the drug label against the patient's medication record. Next, she'll pour and administer the drug, then chart it.

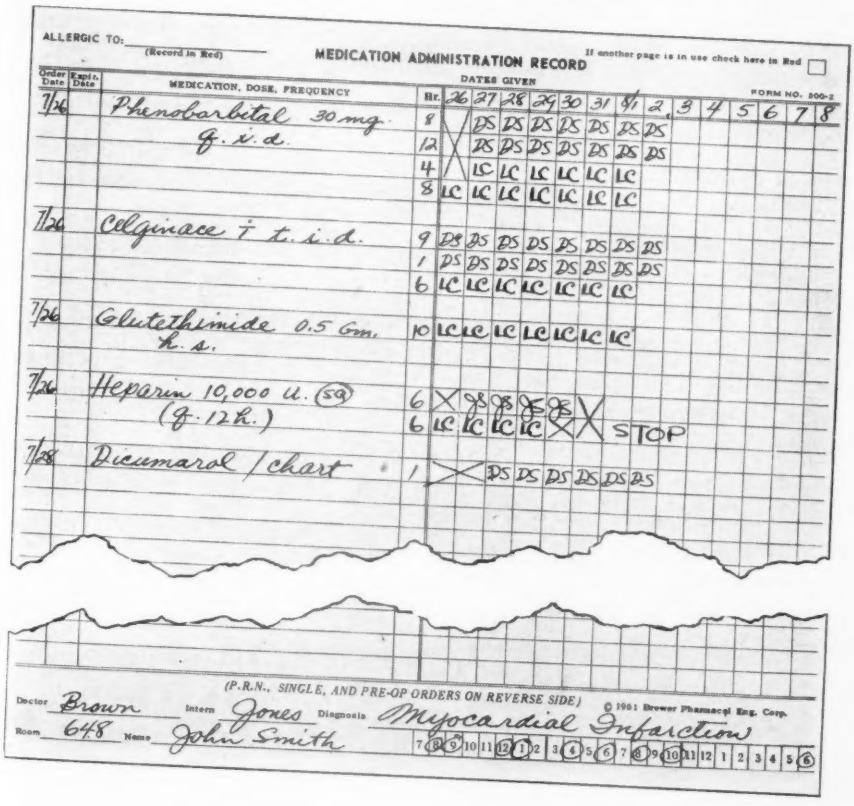
The cart top provides a comfortable working surface. Among the supplies kept in the

compartments visible here are forceps, sponges, paper cups, and sterile syringes.

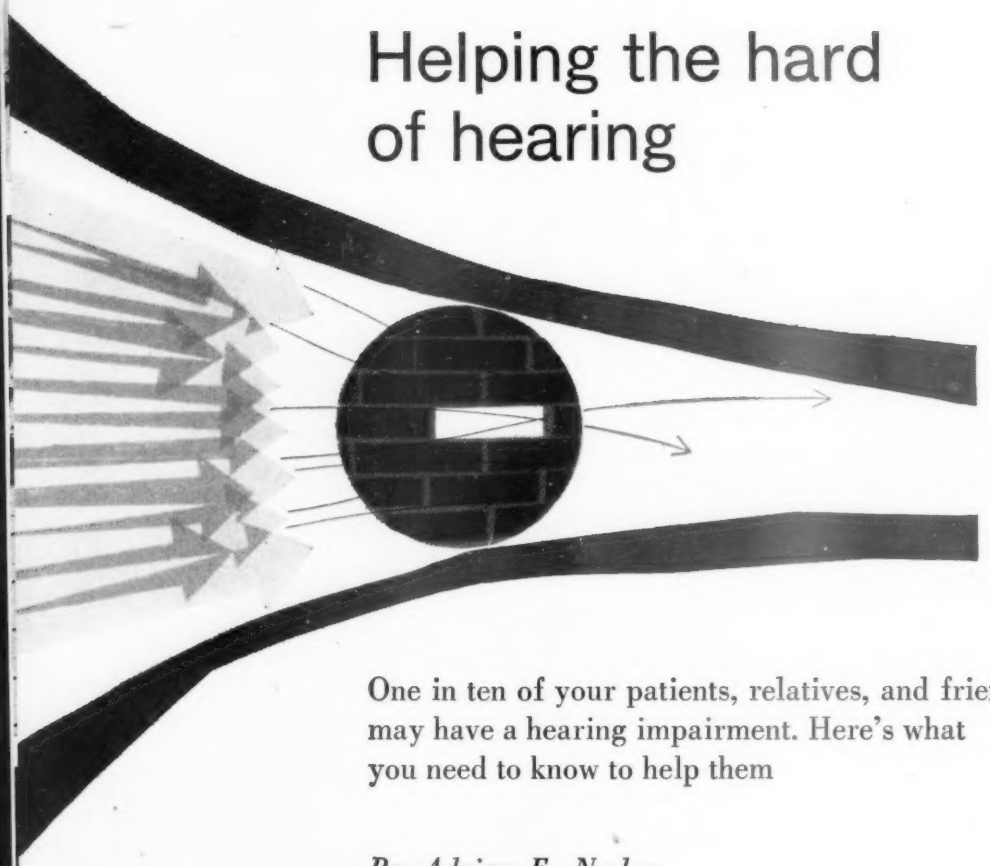
To chart the medication, Mrs. Sitler uses the Brewer Medication Administration Record shown below. This greatly simplifies charting.

One of these forms is made up for each patient from the doctor's written order. The times of administration are indicated by circling the numbers on the "clocks" along the bottom of the form. Each form is placed in a Kardex file so that the patient's name and times of administration show. The file is kept in the drug cart.

As the nurse makes rounds, she checks the Kardex to find which patients should receive medications at that time. She administers each drug, then initials the appropriate box beside the drug name (top of form). This record is part of the patient's hospital chart; so no other nursing notations on drugs are needed. END



Helping the hard of hearing



One in ten of your patients, relatives, and friends may have a hearing impairment. Here's what you need to know to help them

By Adrian F. Nader

Anyone who has a relative or friend with a hearing loss knows what a trying handicap this can be.

Hearing loss is the most common physical impairment in the nation. It strikes people of every age, from birth on. An estimated one person in ten suffers from it to some degree (150,000 persons are known to be totally deaf).

Until recent years, little could be done to help those with serious hearing loss. But since the Nineteen Thirties, great strides have been made—especially in corrective surgery. Testing and rehabilitation services are now readily available, too, providing help for thousands not formerly reached.

This is where you, the nurse, enter the picture. Hundreds of people are ignorant of, or misinformed about, these advances. Many suffer for years from a condition that could be corrected or improved. Some mistakenly try to ignore a loss when it starts. They become caught in an emotional trap that can wreck their lives.

Gradual or abrupt loss of hearing, say psychiatrists, can cause a serious psychic conflict. The victim finds himself on the defensive. As he strains day after day to hear what is said, he may lose his self-confidence. He may become increasingly withdrawn, or he may become demanding and harsh toward others.

The information that follows will help you answer the questions of patients and friends with a hearing impairment. To start, let's review the kinds of impairment and their causes.

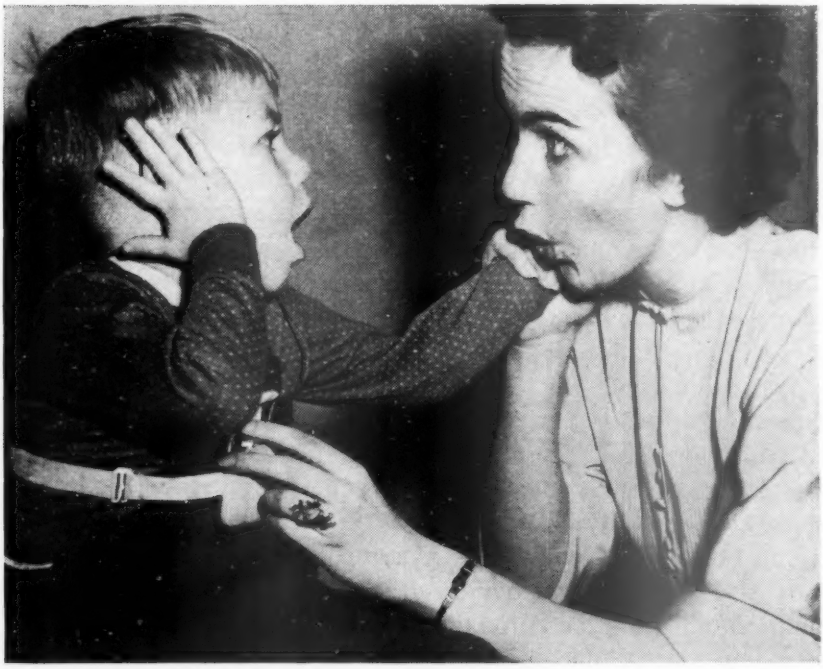
Conductive impairment results when, for any reason, sound vibrations are partially or wholly prevented from passing through the outer and middle ear to the inner ear. The impairment may be caused by trauma; by infection of the external canal or the eardrum or the middle or inner ear; by blocking of the eustachian tubes by infection, or allergy, or en-

larged adenoids; by mechanical obstruction (such as excessive wax in the external canal) or scar tissue on the eardrum or bony formation (otosclerosis) in the middle or inner ear.

Perceptive (nerve) impairment involves the inner ear and its nerves. It may be caused by trauma or infection or excessive noise. There's also evidence that some of the broad-spectrum antibiotic drugs cause this type of damage.

When both the above impairments are present, the hearing problem is called *mixed deafness.* If the cause is emotional or psychologic, it's called *psychogenic deafness.*

Hearing loss may be either *temporary* or *permanent.* Temporary loss (conductive or perceptive or mixed or psychogen-



SPEECH THERAPY *at the Des Moines (Iowa) Hearing and Speech Center helped this boy so much he's now in a school for advanced children.*

ic) may result from any of the above causes that can be corrected or that correct themselves.

For the most part, perceptive impairment is permanent. A damaged inner ear and its hearing nerves seldom regenerate. There's no surgical therapy and usually no medical therapy that can help the patient.

There's some hope for him, however. If nerve impairment hasn't progressed too far, a prescribed hearing aid is helpful. If the patient is beyond such help, you may want to urge him to take auditory training (to improve his speech) and lip reading. These skills will enable him to communicate with others. They also have a therapeutic effect that could save him from serious emotional trouble.

The patient with conductive impairment can usually be helped. In most cases he will never become totally deaf. But he *must* get competent medical assistance. The doctor will take corrective measures, depending on the patient's difficulty. He may then prescribe a hearing aid for one or both ears. Or he may recommend surgery.

Today, otologic surgeons, using the new high-magnification instruments, can repair outer- and middle-ear structures with an amazing percentage of success. They can reconstruct the ear canal; repair a perforated eardrum (myringoplasty); re-

Agencies that help those with hearing loss

More than 250 public, private, and university-sponsored agencies throughout the U.S. offer help to the hard of hearing of all ages. Many of these agencies are members of the American Hearing Society and are supported by local community chests or united funds. They provide free loan of hearing aids and one or more of these services: hearing tests, instruction in the selection and use of a hearing aid, instruction for preschool hard-of-hearing youngsters and their parents, auditory training, lip reading, employment guidance, and recreational activities.

Consult your doctor or your local phone directory for names and addresses of the agencies in your area. Or write for the list published by the American Hearing Society, 919 Eighteenth Street, N.W., Washington 6, D.C.

construct the eardrum and middle-ear bones (tympanoplasty); free a hardened stapes (stapes mobilization). In severe cases of otosclerosis, they may bypass the stapes with a plastic or stainless steel tube; or remove the otosclerotic formation in the oval window and replace it with a vein or tissue graft; or perform a fenestration.

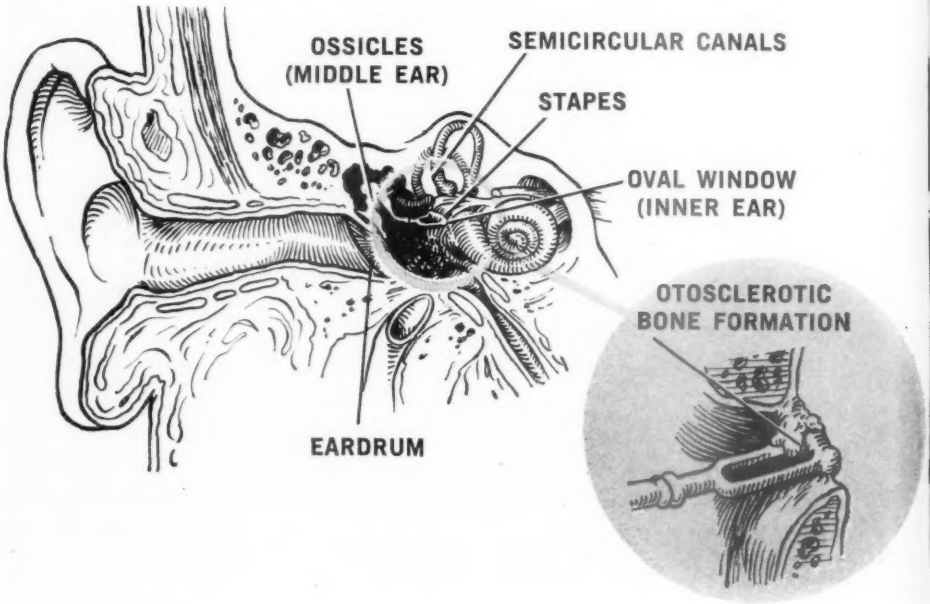
Otosclerosis, say some otologists, is the most common cause of hearing loss. So patients or

Stapes operations and fenestration

These are used *only* for conductive hearing loss resulting from otosclerosis. Here are the procedures:

In *total stapes mobilization* (revived in 1952), the surgeon frees the stapes and its footplate from the otosclerotic formation (see ear sketch). Used widely for a time, this operation has largely been replaced by more recent techniques.

In today's stapes operation, a



friends may ask you about it.

No one knows what causes an otosclerotic condition to develop. But we do know there's an hereditary background, and hence the condition is present at birth. Hearing loss from otosclerosis may start early in life but usually doesn't begin till the teens or as late as the thirties.

The loss doesn't progress at a set rate. In one person, growth of otosclerotic bone may stop suddenly, thus stabilizing the

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total or *partial stapedectomy* is performed. The surgeon removes the otosclerotic stapes or works around the otosclerosis. In working around the otosclerosis, he may make use of the normal, uninvolved portion of the stapes in performing an anterior crurotomy. In a total stapedectomy, the stapes is replaced with a tissue graft or vein graft and an artificial stapes of stainless steel or polyethylene tube.

The stapes operation is performed under local anesthesia and is seldom painful. If surgery is limited to the stapes itself, the patient usually is able to leave the hospital the next morning. If removal of the stapes is involved, he's hospitalized for two or three days.

Usually, hearing improvement is immediate and the restored near-normal hearing is permanent. If the stapes is removed, a period of from three to eight weeks may be required for complete healing and restoration of hearing.

Fenestration may be used when the stapes window is filled with mountainous otosclerosis. Local or general anesthetic is given. The surgeon drills a new window—usually in the ear's external semicircular canal. He covers this with a graft.

The fenestration patient spends a week or more in the hospital, followed by two or three weeks at home. He may suffer dizziness and other side effects at first. Statistics show there is some hearing improvement in four out of five cases.

Source: J. Brown Farrior, M.D. For further information see his "Atlas: Stapes Operations in 3-D," Stapes Anatomy and Pathology, American Academy of Ophthalmology and Otolaryngology, 1961.

level of hearing. In another, growth may continue until it involves the inner ear, thus causing the hearing nerve to deteriorate.

If your patient or friend has a family history of deafness, you'll want to urge him to get regular check-ups. If otosclerosis is the diagnosis, the doctor will decide whether an operation is advisable, and when (see page 62).

Hearing loss in children poses a special problem. It's much more widespread than commonly supposed. The earlier it's detected, the better the chance of helping a child. (Infants can be tested for response to sound as early as three weeks.)

Even when there's no reason to suspect an hereditary condition, impairment can be caused prenatally by congenital defect or Rh incompatibility or maternal rubella (German measles). It can be caused, too, by labor or birth complications. Postnatally, high fever from any cause, skull injury, meningitis, measles, mumps, middle-ear disease, and pertussis, may impair the hearing.

Now, how can you help a patient or friend who wears a hearing aid?

First, you'll understand that, in most cases, the aid does *not* solve his hearing problem completely. Understanding this, you'll place yourself where the patient can see you when you talk to him. You'll speak clearly, without shouting. When nec-

Continued on page 92

How to check your hearing

Sometimes, says the American Hearing Society, a person ignores signs of hearing difficulty when he should be getting treatment that might head off more serious loss. If you're doubtful about *your* hearing, it suggests you ask a close relative or friend to answer these questions for you:

Do I strain to hear or habitually have to turn one ear toward the speaker?

Do I frequently ask that words or phrases be repeated?

Do I fail to understand a speaker when my back is toward him?

If the answers are "Yes," then your hearing probably isn't up to par. The next step: take a hearing test.

They helped bring Hope to others

Recently the S.S. Hope returned to San Francisco from Southeast Asia, ending the first privately sponsored shipborne medical mission in history. Soon the twenty-seven nurses who spent a year aboard will be back at their former work in many states. Meanwhile, the People-to-People Health Foundation, sponsor of the Hope, is raising funds to make a second cruise possible. What was life like aboard the Hope? Do the R.N.s feel that their teaching mission was a success? Here, two Hope nurses, Teresa Campbell, R.N., and Elizabeth Ahern, R.N., share their experiences with you in letters that were written while the ship was in Indonesia.

Teresa Campbell, R.N.:

This is a strange and beautiful land. As I reflect on the many places our ship has visited, I recall sights I shall never forget:

Lovely islands, surrounded by calm blue waters. Thatched huts, rice fields, tea plantations. Countless smiling faces: tanned, exquisitely featured, with huge brown eyes . . .

Malnutrition and disease are common here. Some 90,000,000 people live on this nation's 3,000 islands. The land cannot begin to produce enough to meet the people's needs. Many survive on an inadequate diet. Malaria and appendicitis are major medical problems. Amputation is still the treatment for compound fracture. There are less than 1,000 doctors. Many of the outer islands are without medical facilities. . . .

Our voyage from San Francisco to Djakarta, the Indonesian capital, took about a month. We were busy daily from 7 A.M. to 10 P.M. organizing the hospital, setting up wards, cleaning bunks and mattresses, writing procedures. Every night two Indonesian girls instructed us in the language and culture of their country. We soon forgot the basic language lessons, but we didn't forget those words which were pertinent to nursing care, such as "This won't hurt."

The first few days out, I almost starved until I found my way to the galley. We had lots of fun getting used to shipboard life. One day I answered the call of "Flying fish on the top deck aft!" As I bent over to see the fish (which, supposedly, were under a box), I received a resounding whack on the posterior. . . .

Finally we arrived at Djakarta, on the island of Java. It seemed as though the city's entire population was at the dock to greet us. Within a week, President Sukarno visited the ship and we had the opportunity to meet him. Within the first few days, we welcomed the thirty-two Indonesian nurses who were to remain aboard during our stay. We were amazed at the large number of male nurses in Indonesia. (The Moslem religion requires that male patients be cared for by male nurses.)

The people of Indonesia are reserved but friendly. They have offered us unlimited hospitality. We have all been guests in their homes and participants in their social activities. One thing we've noticed in particular: They seem to view life and death in a more casual manner than Americans, perhaps because of the philosophy derived from their Buddhist, Moslem, and Hindu religions.

We are here primarily for

OPEN COOKING FIRES *cause many bad burns among Indonesian children. Here Teresa Campbell prepares a 13-year-old girl for surgery to repair the scar tissue on her thigh. This was one of several hundred operations performed aboard the Hope.*

teaching purposes. Therefore, patients whose illnesses satisfy this purpose are selected by American and Indonesian doctors. They are brought to the Hope through the admission clinic where they receive a routine examination, including stool studies for parasites and ova.

The Hope has six wards: two medical, two surgical, one pediatric and one postoperative unit. The patients are keenly interested in all the activity and soon adjust to routine.

Our Indonesian nurses are eager to learn. A short time after joining us, they were carrying out their share of the ward assignments and taking part in nursing-care seminars as well. All American nurses participate in the in-service education program.

Depending on our port of call, we care for patients either aboard ship or ashore. For example, at the island of Bali our ship was anchored a distance off shore; so our teams worked with local staffs in their hospitals.

Our main area of concentra-

Facts about the Hope and its mission

The ship: Former hospital ship Consolation, on loan without charge from the U.S. Navy.

The cost: $3,500,000 for the ship's cruise, provided by voluntary contributions to the People-to-People Health Foundation, 1818 M Street N.W., Washington 6, D.C.

The medical personnel: 10 doctors, 27 nurses, 2 dentists, 11 technicians, 1 physical therapist; 46 medical specialists serving in rotation without pay during the stay in Indonesia.

The medical facilities: 6 wards with 260 beds; 3 O.R.s; 1 eye,

tion is nursing care. We set up postoperative wards, dressing carts, etc. We also teach classes, at the request of Indonesian nurses, in subjects such as ward administration, team nursing, sterilization, and nursing theory and practice. There is a glaring lack of nursing instructors here, but the nurse-teacher school in Bandung is working hard to improve the situation.

At Bali we observed the local leprosy-control program, directed by a British doctor under contract to the Indonesian Government. (The incidence of this disease is as high as eighteen per 1,000 persons.) Tremendous progress is now being made. The government subsidizes leprosariums so that patients in advanced stages of the disease may live apart and, where possible, become self-sufficient. . . .

In remote areas, we found the dukun—persons with little or no medical training who treat their patients by primitive methods. An attempt is being made to educate them, with emphasis on asepsis. Our two Hope midwives taught some of them

1 OB/gyn., 1 ENT clinic; 3 dental units; 4 X-ray and fluoroscope units; 3 classrooms, including one with closed-circuit TV.

The work in Indonesia (ending June 1): 11 Indonesian M.D.s and technicians (32 Indonesian nurses lived aboard) visited 20 cities and surrounding areas; conducted 800 classes and seminars at 22 hospitals and elsewhere; performed 660 operations; treated 17,500 patients; distributed 2,000 artificial arms and legs, 2,000 medical books, 4,000 medical journals, 80,000 pounds of milk, 86,000 pounds of other medical supplies and equipment.

The work at Saigon, South Vietnam (starting June 15): Formal teaching program aboard in all specialties for Vietnamese internes and nurses.

techniques of delivery and postpartum care.

We're seeing disease conditions that have long been absent in the U.S. Yaws is now under control, but one still finds diphtheria and smallpox. Tetanus is widespread. However, increasing efforts are being made toward prevention. . . .

Looking back on the months we've spent in Indonesia, I realize what a privilege it has been to serve on the S.S. Hope.

Elizabeth Ahern, R.N.:

At Sumbawa we set up a polyclinic in an old shed ashore, just off a primitive jetty where our boats could dock.

Our public health nurses had written a procedure manual for just such a situation. Supplies were boxed and ready for unloading when we arrived. We went ashore early in the morning, while the air was cool. Soon we were so busy we did not notice the heat. Everyone pitched in.

First, we divided the dirt-floored shed into five areas. Our R.N.s set up four examining centers and a pharmacy table. Other personnel set up a treatment table. Some crew members erected a large tent beside the shed to house our lab. Others spread a tarpaulin for waiting patients to sit on; then they installed an incinerator they had made aboard ship. Before we left, local officials posted guards to prevent stealing.

While our clinic was taking shape, another building appeared near the jetty—a W.C. made of gleaming corrugated iron. It was built by local workmen as their contribution to our project. As is the custom, it had a swinging door!

Soon the clinic was ready and patients were waiting. To help with asepsis, examining tables were covered with plas-

WATCHING THE AMERICAN NURSE *was a favorite pastime of Indonesians at many of the shore clinics. The R.N. is Betty Ahern, in her blue going-ashore uniform. She's setting up for the day's work at the clinic at Kupang, island of Timor.*

tic. They were scrubbed between patients. Disposable pads were placed under patients as needed. Urine specimens were obtained in paper cups. Emesis basins and soiled equipment such as nasal specula and otoscope parts were washed with antiseptic soap and water. Vaginal specula were washed after use and returned to the ship to be boiled. Water was brought from the ship.

The Hope's boats shuttled back and forth, transporting patients who needed treatment aboard. Patients requiring tests and X-rays also were sent to the ship. Our pediatricians dispensed ten-pound containers of powdered milk to the mothers of malnourished youngsters.

Our Indonesian girls were good interpreters as well as nurses. The clinic served as a classroom for teaching many skills. . . .

At Makassar, on Celebes, we

set up a two-week teaching program at the local hospital. Each class was planned by an American and an Indonesian nurse of our Hope staff. The Indonesian nurse did the teaching, with the American available for questions. We stressed the setting up of a simple dressing cart, changing dressings, injections, sterile and clean techniques, pre- and postoperative care (with emphasis on turning and deep breathing).

The local nurses carried on lively classroom discussions. To start a discussion, we would ask them how they do a procedure; then we would tell them how we do it. Many times we combined elements of their methods and ours. For instance:

The hospital had a limited supply of sterile dressings. The water system was so unreliable that water usually had to be carried into the wards. Resulting problem: What could we do to maintain clean technique when changing dressings?

Our solution: (1) Set up basins of water with soap in the wards for hand-washing between patients. (2) Pour alcohol into the dressing-cart basin that contains the dressing forceps. Set it afire. Basin and forceps then provide a sterile field for the next dressing.

Most of the patients kept to their beds. There was little socializing. But with our encouragement, those who were am-

Continued on page 94

Dressing lesson

While I was working in an emergency room a young couple brought in their screaming 1-year-old. They thought he'd swallowed something. The doctor hurriedly examined, manipulated, and finally pumped out the boy's stomach. He still screamed wildly.

I started to undress him. As soon as I removed his left shoe, there was silence. There was also the answer to the mystery: Two of his toes had been bent back by his mother when she put his shoe on. —JOYCE F. BARRIER, R.N.

Drugs in the management of bronchial asthma

BY MORTON J. RODMAN, PH.D.

The person suffering a severe asthma attack is a picture of distress. His face is pale and fearful. His breath comes in wheezes and whistles as he struggles to get air in and out through narrowed bronchial tubes clogged with thick secretions. His labored breathing is broken by fits of unproductive coughing that leave him limp and exhausted.

Fortunately for the asthma victim, doctors are well armed today with weapons that act swiftly to relieve the hunger for air, the choking, and the coughing. Cures for this disease are still hard to come by; but acute attacks usually yield to several types of drugs now available. So patients with chronic asthma *can* be kept more comfortable.

Asthma is mainly allergenic or infectious in origin. Long-range control depends in large part on finding the offending allergens or agents and excluding or controlling them. Once the doctor has found a specific allergen, he may reduce a patient's sensitivity (hyposensitization) by preparing an extract of the allergen and injecting it in increasing strengths over a long period.

Of course, it isn't always possible to identify the responsi-

THE AUTHOR *is Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N.J., and a consultant to the U.S. Public Health Service and other agencies.*

ble substance. Too, hyposensitization 'procedures may not give complete relief. In such cases, drugs that control severe symptoms are especially valuable.

The most effective of these are the adrenergic bronchodilators, especially epinephrine (Adrenalin, et al.) and isoproterenol (Isuprel, et al.) Given by injection or inhaled, they relax the bronchiolar walls, stopping spasm and allowing air to pass in and out more readily.

These valuable drugs have two main drawbacks: relative-

Some asthma-management agents

Entries on this list start with the official or generic name of each drug, **followed in** parentheses by its trade name(s) **and/or** synonym(s).

Adrenergic bronchodilator-decongestants

Cyclopentamine HCl, N.F. (Clopane)
Ephedrine (and its salts), U.S.P., N.F. (Efedron, Ephetonin, Ionephrin, et al.)
Epinephrine (and its salts), **U.S.P., N.F.** (Adrenalin, Episcorb, Sus-Phrine, et al.)
Ethylephedrine (Nethamine)
Ethylnorepinephrine HCl (Bronkephrine, Butanefrin)
Isoephedrine HCl (Pseudoephedrine, Sudafed)
Isoetharine HCl (Dilabron)
Isoproterenol HCl, U.S.P. (Isuprel)
Isoproterenol sulfate, N.F. (Isonorin, Medihaler-Iso, Norisodrine)
Methoxphenamine HCl, N.N.D. (Orthoxine)
Phenylephrine HCl, U.S.P. (Neo-Synephrine)
Protokylol HCl, N.N.D. (Caytine)

Theophylline-type bronchodilators

Aminophylline, U.S.P. (Theophylline ethylene diamine)
Diphylline, N.N.D. (Neothylline)
Oxtriphylline, N.N.D. (Choledyl)
Theophylline methylglucamine, N.N.D. (Glucophylline)
Theophylline monoethanolamine (Clysmathane)
Theophylline sodium glycinate, N.F. (Glynazan, Glytheonate, Synophylate, Theoglycinate)

Drugs for facilitating bronchial drainage

Ammonium chloride, U.S.P.
Calcium iodide
Glyceryl guaiacolate (Robitussin)
Iodinated glycerol (Organidin)
Iodobrassid (Lipo-Iodine)
Ipecac, syrup, U.S.P.
Pancreatic dornase, N.N.D. (Dornovac)
Potassium iodide, U.S.P.
Sodium iodide, U.S.P.
Sodium-2-ethylhexyl sulfate (Tergitol)
Superinone (Alevaire)

ly short action and potential toxicity. Today, epinephrine can be made long-lasting by administering it in slow-release forms such as Adrenalin-in-Oil and Sus-Phrine. A single injection of a suspension at bedtime is said to permit patients who otherwise would be awakened by wheezing attacks to sleep throughout the night.

Isoproterenol is safer than epinephrine for patients with high blood pressure. But high doses can cause cardiac palpitation and arrhythmia. So dosage has to be controlled carefully in patients with heart ailments.

The new pocket-sized nebulizers help do this. They release a measured amount of the bronchodilator as a fine mist. A single squeeze of the Isuprel Mistometer, for instance, is said to give dramatic relief from most acute asthma attacks without causing systemic side effects.

A similar aerosol product called Bronkometer works thus: The patient puts a mouthpiece between his lips, inhales deeply, and presses down on the nebulizer. A mist of several drugs goes deep into the respiratory tree. In this product, a new adrenergic called isoetharine (Dilabron) is combined with phenylephrine (Neo-Synephrine) and an antihistamine.

Phenylephrine constricts dilated blood vessels in the bronchiolar walls. This produces prompt shrinkage of swollen membranes. The action of the

Synthetic adrenocorticosteroids

Betamethasone (Celestone)
Dexamethasone, N.N.D. (Decadron, Deronil, Gammacorten)
Methylprednisolone, N.N.D. (Medrol)
Methylprednisolone sodium succinate, N.N.D. (Solu-Medrol)
Paramethasone acetate (Haldrone)
Prednisolone phosphate sodium, N.N.D. (Hydeltrasol)
Prednisone, U.S.P. (Deltasone, Deltra, Meticorten, Paracort)
Triamcinolone, N.N.D. (Aristocort, Kenacort)

Miscellaneous agents

Atropine sulfate, U.S.P.
Brompheniramine maleate, N.N.D. (Dimetane)
Corticotropin, purified, N.N.D. (ACTH, et al.)
Diphenhydramine HCl, U.S.P. (Benadryl)
Ethamivan (Emivan)
Meperidine HCl, U.S.P. (Demerol)
Trishydroxymethylaminomethane (THAM, tris buffer)

combined drugs opens blocked bronchial tubes, making it easier for the patient to cough up thick mucus stuck deep in the narrowed air passages.

Ephedrine is still the old stand-by for preventing asthma attacks or managing mild ones. It's best given in combination with aminophylline, a drug that seems to potentiate its bronchodilating action. Barbiturates usually are added to prevent insomnia and jitteriness.

When aminophylline is given intravenously, it may dramatically terminate a severe asthma attack in patients who don't respond to ephedrine. The doctor is careful to give it slowly and in small doses to avoid any untoward heart effect.

Aminophylline is also given by mouth; or it may be administered rectally as a suppository or retention enema. A solution of one of its chemical relatives, theophylline monoethanolamine, is now available as Clysmathane, a single-dose enema in a disposable squeeze bottle.

When aminophylline alone is given orally in the usual dose, its effectiveness is questionable. (Larger doses are often irritating to the stomach.) But a recent liquid preparation of theophylline called Elixophyllin may be given orally in relatively large doses with reportedly good effect.

Antihistamines often are combined with bronchodilators in cough syrups for children. Some asthma specialists question the effectiveness of such combinations. In theory, the antihistamine drugs should help keep allergy-released histamine from affecting the bronchial tissues. Often they don't, say the specialists. What's worse, they may have a drying action on bronchial secretions, thus aggravating the patient's asthma.

Expectorants are the best cough medications for asthma because they liquefy thick mucus that may set off cough paroxysms and bronchial spasms. In the past, the most dependable expectorants have been those containing potassium iodide, or the calcium and sodium salts of iodine. In recent years, glyceryl guaiacolate (Robitussin) has found favor as a mucus-thinner, especially in patients who suffer skin rashes and other side effects from the iodides.

Wetting agents also are used

to help liquefy sticky secretions and make them easier to drain. Among these are detergents such as superinone (an ingredient of the product Alevaire) and sodium ethylhexyl sulfate (found in Tergemist in combination with potassium iodide). Breathed deep as a fine mist, these agents reduce the surface tension of sputum, liquefying it. Other aerosols that contain enzymes, such as pancreatic dornase (Dornovac), act differently but accomplish the same result.

The bronchodilators and expectorants together can keep

legal pointer

QUESTION: *In the emergency room, a physician usually gives medication orders orally. These can be easily misunderstood. Should the nurse protect herself by requesting written orders?*

ANSWER: It's impractical to request written orders in the emergency room. The physician may be working swiftly to stop massive hemorrhage, for instance. In such circumstances, verbal orders are legally justified. Most hospitals require that orders be repeated to the prescribing physician before they are carried out. This is a legal criterion of good practice. The supervising nurse can protect herself and other R.N.s by seeing to it that this practice is strictly observed and that orders are carried out promptly and recorded as soon as possible. Each recorded order should be signed *by the physician who prescribed the medication.*

DO YOU HAVE A QUESTION *about some legal aspect of nursing? If so, send it to William A. Regan,* LL.B., *care of* RN. *He'll select questions for reply on the basis of their general interest to readers. No questions can be acknowledged or returned.*

most asthma symptoms under control. But the adrenocorticosteroids and corticotropin (ACTH, et al.) also are helpful. For instance:

¶ Daily oral doses of steroids have enabled patients crippled by chronic asthma to lead normal lives.

¶ When other measures have failed, I.V.-administered methylprednisolone sodium succinate (Solu-Medrol) has brought dramatic relief to patients with acute status asthmaticus.

In administering the steroids, doctors give the smallest doses that will control severe symptoms. They're also alert to the danger signs of steroid complications.

Among the most potent synthetic steroids used for asthma are dexamethasone (Decadron, Deronil, Gammacorten) and two newer drugs, betamethasone (Celestone) and paramethasone acetate (Haldrone). All are given in relatively high doses until asthma symptoms are relieved. Then the doctor gradually reduces the drug to a low level or discontinues it. He may administer corticotropin during this tapering-off period to stimulate the patient's drug-weakened adrenal glands to produce more anti-stress hormones.

A number of miscellaneous agents seem promising. Consider the treatment of respiratory acidosis, for example. Acidosis is one of the most serious asthma complications. It may occur when the patient develops emphysema, a condition in which the alveoli become overstretched and fail to rid the blood of carbon dioxide waste. The pile-up of this acid gas may then bring on convulsive seizures, coma, and respiratory or cardiovascular failure.

Two new drugs are getting a trial in respiratory acidosis. The first, an analeptic agent called ethamivan (Emivan), stimulates the depressed respiratory centers, increases the exchange of gases, and eliminates excess carbon dioxide. The second, a buffer called trishydroxymethylaminomethane (THAM), binds the excess carbon dioxide. When infused into a vein of a comatose patient, it combats acidosis and overcomes gas-induced narcosis. (It's still in the experimental stage.)

Heart stimulants and antibiotics are used in some condi-

tions that complicate the management of asthma. For instance, digitalis-type drugs may be given when pulmonary obstruction threatens to overload the heart. Penicillin, streptomycin, and tetracycline-type antibiotics may be used to fight acute respiratory tract infection.

Sedatives and tranquilizers are useful too—particularly for the patient suffering the continuous paroxysms of status asthmaticus. The patient's fear of suffocation tends to tire him out and keep the attack going. So his doctor may give drugs to keep him quiet and sleepy, yet wakeful enough to cough up mucus.

For some patients, psychotherapy plays a part in controlling asthma. For most patients, relaxing surroundings can do much to help abort acute attacks. A calm, confidence-inspiring doctor and a cheerful, friendly nurse are "good medicine" for the tense, nervous asthma patient. END

Metered delivery

I was the doctor on duty in the emergency ward. A man raced in and stammered, "My wife's having a baby outside." I grabbed a pair of sterile gloves, signaled to the nurse to bring the delivery pack, and followed the expectant father to a taxi in the driveway. In the back seat was a woman in the second stage of labor. There was no time to get her into the hospital.

The nurse and I set about taking care of our patient. The driver paced frantically beside his cab. Finally he stuck his head in and asked in a shaking voice: "Isn't there *something* I can do?"

"There certainly is," said the nurse. "Turn off your meter. It's still running." —ELMER ZINNER, M.D.

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address: Anecdotes,* RN, *Oradell, N.J.*

My work is a labor of love

This nurse's unusual specialty allows her to give total, personal, uninterrupted care to all her patients

By Constance Pomeroy, R.N.

Childbirth is a terror-filled experience for many mothers mainly because they go through labor virtually alone. If nurses were at hand to give them constant support, these mothers would be far more likely to bear their babies in pride and dignity, with a minimum of emotional trauma.

Today such support is impossible in most hospitals. Sometimes there's only one R.N. on the labor floor. She must care for several patients, prepare for deliveries, write up charts, etc.

She hasn't time to sit with patients or otherwise give them the support they need. So both nurse and patients feel cheated.

But come with me to St. Luke's Hospital in San Francisco, where two other R.N.s and I are private labor nurses for the patients of three obstetricians. Here the situation is different. Let me tell you briefly about our job.

We're employed by the doctors, not by the hospital. Thus we serve their patients only. We work on call any number of hours from none to twenty-four per day.

THIS ARTICLE *has won an* RN *Award for its author.*

The work is demanding, both physically and emotionally. Aside from answering calls, we teach exercise classes for our doctors' patients and childbirth classes for patients and their husbands. Occasionally we help at the doctors' office. We've been tapped, at various times, as resource people for a parents' group and as lecturers for nursing classes, physiotherapy classes, college classes in marriage preparation, and parents' classes at the Red Cross—all on our "free" time.

A slave-labor routine? Maybe, by some standards. But we don't think so. For *we* have found what many older R.N.s say has been lost to nurses in this day of paper work: *We've found the immeasurable satisfaction that comes from giving personal and total patient-care.*

Many other nurses seem to miss this kind of satisfaction and to be looking for a way to achieve it. Whenever a vacancy occurs in our ranks, there's a line-up of eager applicants that would make any hospital supervisor envious.

Just what does a private labor nurse do, aside from the incidental tasks already mentioned? Join me now, while I care for a typical patient.

Please understand: I have no responsibility except the patient. I commit myself totally to her physical, emotional, and intangible needs. I stay with her from the moment she arrives until delivery is completed. My major purpose is to reassure her and make her as comfortable as I can.

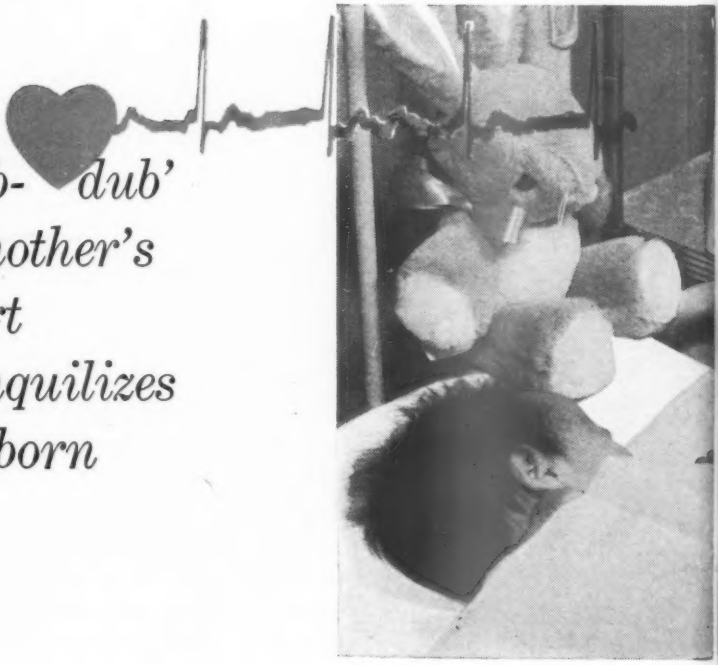
First, I take care of the admissions procedures and the patient's physical needs. For example, I do the prep and enema, check blood pressure, listen to the fetal heart, and make sure the patient is adequately covered and that her bed is clean and dry.

The simple fact that she knows I'm there, sitting beside her, helps her surprisingly. So does the back rub I give when her contractions become more

intense. My explanations help, too—as, for instance, when I explain that the intensified backache means the baby's head is passing through the pelvis and that this is a sign of progress.

While I reassure her, I encourage her to express her fear. I point out that fear is normal and nothing to be ashamed of. I help her not to panic by coaching her in relaxing and breathing techniques. This requires concentration that takes her mind off the contractions. Here's an example:

When a contraction starts, I place a hand on the fundus of the uterus and say in a low, calm, reassuring voice: "Breathe where my hand is. Take big, deep breaths. Keep your legs loose. Relax. That's it. Breathe where my hand is. Again.



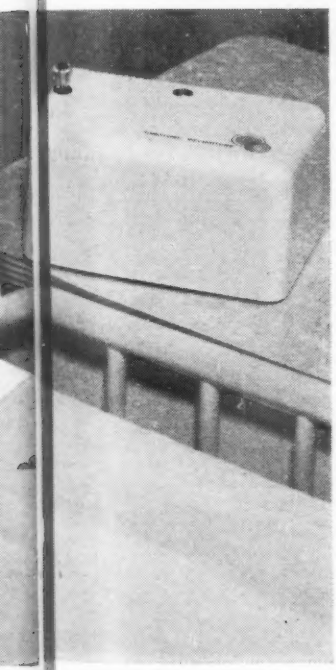
'Lub-dub' of mother's heart tranquilizes newborn

You're doing fine now. Keep it up."

As she approaches the end of the first stage of labor (full dilatation of the cervix), I tell her: "You'll soon feel the desire to bear down." After I make sure she's in the second stage, I may encourage her to push with each contraction. (We encourage most primaparas and some multiparas to push in the labor room, but always under direction.)

By reassuring her at each step of the way and by explaining that she's making progress, I help her to realize that she's accomplishing something important—something that only she alone, and not the nurse or the doctor, can do.

I point out that while nurse and doctor may help somewhat,



This tiny patient sleeps to the soothing accompaniment of a sound he associates with his prenatal security: the "lub-dub" of a mother's heartbeat. The sound is reproduced by the electronic device shown at his cribside.

The machine—called a "heartbeat comforter"—benefits the newborn in several ways, says Dr. Richard C. Reed who has tested it at units of the United Hospitals of Newark (N.J.): Infants sleep better, cry less, and gain weight more readily than those not exposed to its rhythmic sound; and their pulse and respiratory rates become more normal.

Developed by Dr. Lee Salk of City Hospital, Elmhurst, N.Y., the comforter is designed to buffer the trauma of birth, to make the newborn feel emotionally secure, and to help them fall asleep quickly. END

she is the heroine of this drama. This is *her* baby, her great moment. Usually, she accepts the idea and takes pride in the effort she must put forth.

If she needs emotional support, I give it. But I don't smother her with sympathy and pity at any time.

If she asks for her husband, I gladly admit him. Often his presence helps considerably. What could be more comforting than for her husband to hold her hand or ease her pain by rubbing her back gently?

Each patient, of course, responds to the stresses of labor in her own way. Each has intangible emotional needs which

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My most unforgettable patient

(With apologies to *RN*'s previous memoirists)

A gay old maid was Miss McQuade,
A bright-eyed pixie, she;
And none would think to see her wink
Her age was ninety-three.

She seemed as spry, this cutie-pie,
As some at twenty-one—
A wit, a wag, who loved a gag
And, better still, a pun.

So when young Doctor Proctor chanced
To give her pulse a squeeze,
Her comment ran: "See here, young man,
No geriatricks, please!"

—AMY COLE, R.N.

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for Pfizer broad-spectrum antibiotics
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formerly named	*now named*
Cosa-Tetracyn® Capsules	Tetracyn® Capsules*
Cosa-Tetrabon® Oral Suspension	Tetracyn Syrup
Cosa-Tetrabon Pediatric Drops	Tetracyn Pediatric Drops

and simpler names for these Tetracyn-containing formulations:

Cosa-Tetrastatin® Capsules	Tetrastatin® Capsules
Cosa-Tetrastatin for Oral Suspension	Tetrastatin for Oral Suspension
Cosa-Tetracydin® Capsules	Tetracydin® Capsules

the name now is simply... **Signemycin®**
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Cosa-Signebon Pediatric Drops	Signemycin Pediatric Drops

*Terramycin and Tetracyn Capsules without glucosamine are no longer available.

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I try to meet. For example, one patient was worried about a baby-sitting problem. I helped her work it out during labor. Another was worried about her mother, who was more upset over the coming birth of a grandchild than she had been over the birth of her own daughter. So I helped work out that problem, too.

When the mother goes to delivery, I go with her. In delivery, the staff nurse circulates, an interne and a student nurse assist the doctor, and I coach the patient. If the mother wants a moderate type of anesthetic, I give it under the doctor's direction. (We usually give nitrous oxide and oxygen for short periods and in low concentration. In some cases the anesthesiologist is called to give general or spinal anesthesia.)

After the delivery, I take the baby to the nursery. Then I transfer care of the mother to the postpartum nurse. Thereafter, I visit the mother to answer any questions about postpartum or baby care.

During our hours with a patient, we private labor nurses and the staff nurses work closely together. The labor nurse's first duty is, of course, to her patient. But her second duty is to all patients. So if the staff nurses are particularly busy, the labor nurse finds ways to help them. Or if the labor nurse needs assistance, the staff nurses help her.

What do the patients think of our service? Here are typical comments:

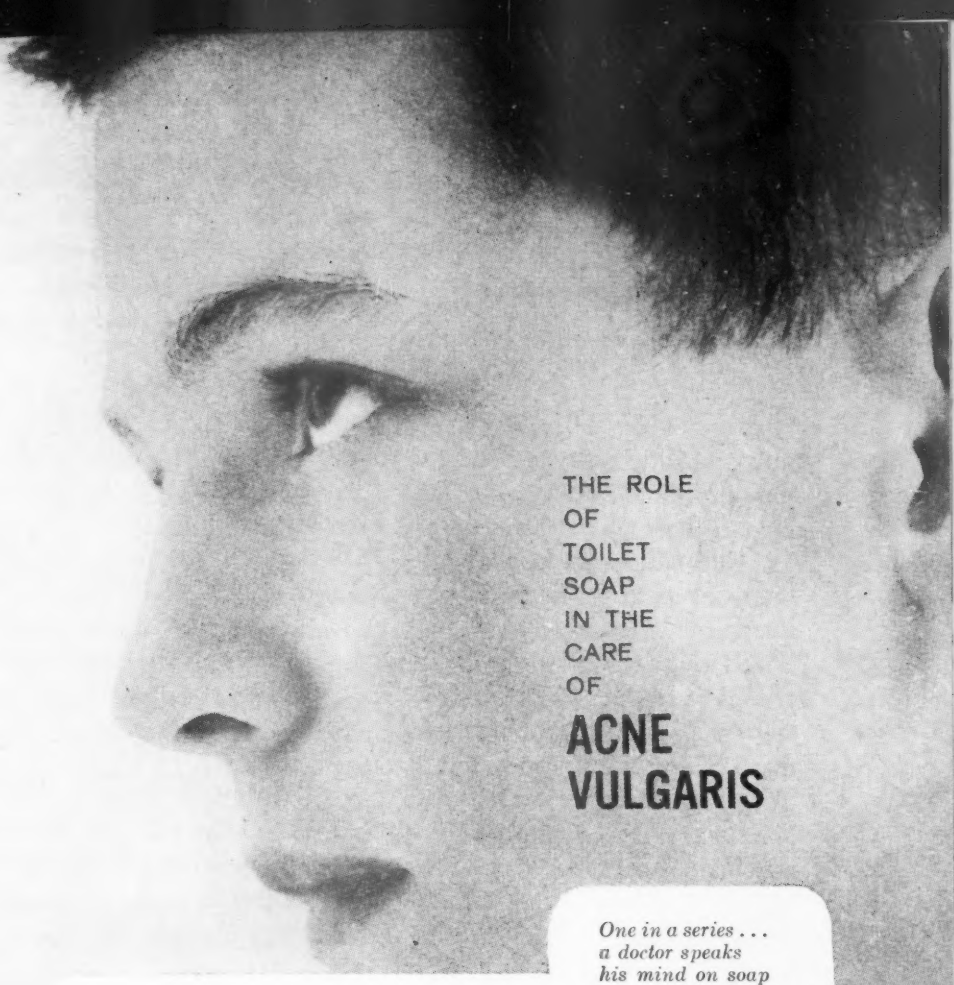
"Having the labor nurse with me helped more than anything else."

"She was patient and helpful beyond words."

"It was a wonderful experience for me and my husband."

This last statement is especially gratifying. Labor is aptly named. It's the hardest work a woman is ever called upon to do. But it's bearable. And, with the help of the nurse, it can be a maturing, satisfying experience (as the quotation shows) rather than a nightmare to be put out of mind as quickly as possible.

As for us, the labor nurses: We're happy we can help even a little. We enjoy a sense of fulfillment because we can give of ourselves without restriction or interruption. For us, our work is truly a labor of love. END



THE ROLE
OF
TOILET
SOAP
IN THE
CARE
OF

ACNE VULGARIS

One in a series . . .
a doctor speaks
his mind on soap

"Local therapy should correct the seborrhea and local infection . . . The skin should be moistened and massaged with a mild soap two or three times a day."

DOWNING, JOHN GODWIN: Medical Clinics of North America, Vol. 39, No. 5, p. 1254 (September) 1955

When a bland soap is indicated, here are some facts from Procter & Gamble that may be helpful: Ivory Soap helps prevent follicular clogging of skin disturbed by seborrhea. In making this mild, pure soap . . . every possible precaution is taken to eliminate ingredients that might disturb skin. As a nurse, you'll be interested in knowing that more hospitals choose Ivory . . . more doctors advise Ivory than any other skin soap! *99 44/100% pure®. . . it floats*

IVORY

The child with diabetes

Continued from page 39

twenty-five or thirty units. He may suddenly respond poorly to the insulin he's receiving and have to be switched to a different kind. Or, he may need more than one kind to continue adequate control.

His diabetes is likely to become worse during illness, a spurt in growth, and puberty. So the doctor checks him every three to six months, at the least. When the child is ill, he's watched with special care. Prolonged vomiting is the greatest danger. If uncontrolled, it may lead to acidosis within eight hours. To control it swiftly, fluids with sugar are given, plus antiemetic drugs such as Thorazine or Compazine suppositories.

* * *

The foregoing are the basic facts useful to the nurse. Here are some questions mothers may ask, with the answers:

Should I keep my child's diabetes a secret?

No. This would emphasize it in the child's mind and make him feel different from others. But don't stress it too much.

How will the disease affect his growth and development?

Chances are he'll keep pace with other children. But puberty may be somewhat delayed. Child diabetics usually are bright and do well in school.

Are complications likely to develop? If so, what are they?

Good control helps prevent complications. The most dangerous is vascular disease, affecting the eyes or the kidneys or other organs. It may show up in ten to fifteen years after the onset of diabetes.

Is the diabetic's life expectancy less than other children's?

Statistically, yes. But for the individual, good control and avoidance of complications will help him live as long as many nondiabetics and longer than others.

Will my daughter be able to marry and to have children?

She certainly can marry. And she has an 85 per cent chance of delivering a healthy baby. Of course, pregnancy and childbirth require special medical supervision. But childbearing isn't nearly so hazardous for today's

*without causing constipation!

Pink Pepto-Bismol® checks common diarrhea without causing constipation; protects intestinal mucosa with soothing coating action. Relieves abdominal cramps, digestive upset, nausea, "gas pains," g.i. irritation. Safe for children and adults. Contains no sugar—may be used by diabetics. (Contains: Bismuth Subsalicylate, Salol and Zinc Phenolsulphonate in a demulcent base. Note: Temporary darkening of stools may occur due to bismuth salts.)

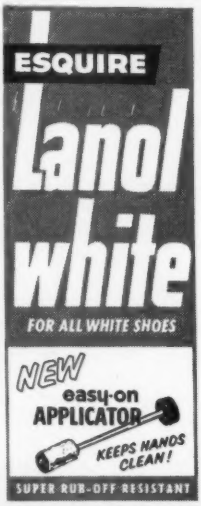
NURSES KNOW BEST!

that's why they prefer

ESQUIRE LANOL-WHITE

Esquire Lanol-White is by far the favorite white shoe cleaner of "women in white." Doesn't just cover up dirt, but actually removes it. Glides on smooth and even, gives a "whiter-than-new" white. And Lanol-White won't rub off, like many other white shoe cleaners. Contains Lanolin, too —to keep leather soft. Remember — "When Lanol-White's ON, dirt's GONE!"

Now! with the handy "EASY-ON" APPLICATOR right in the bottle!



diabetic as it once used to be.

Will my son be able to father children?

Probably. There's no statistical difference in fertility between diabetic and nondiabetic men.

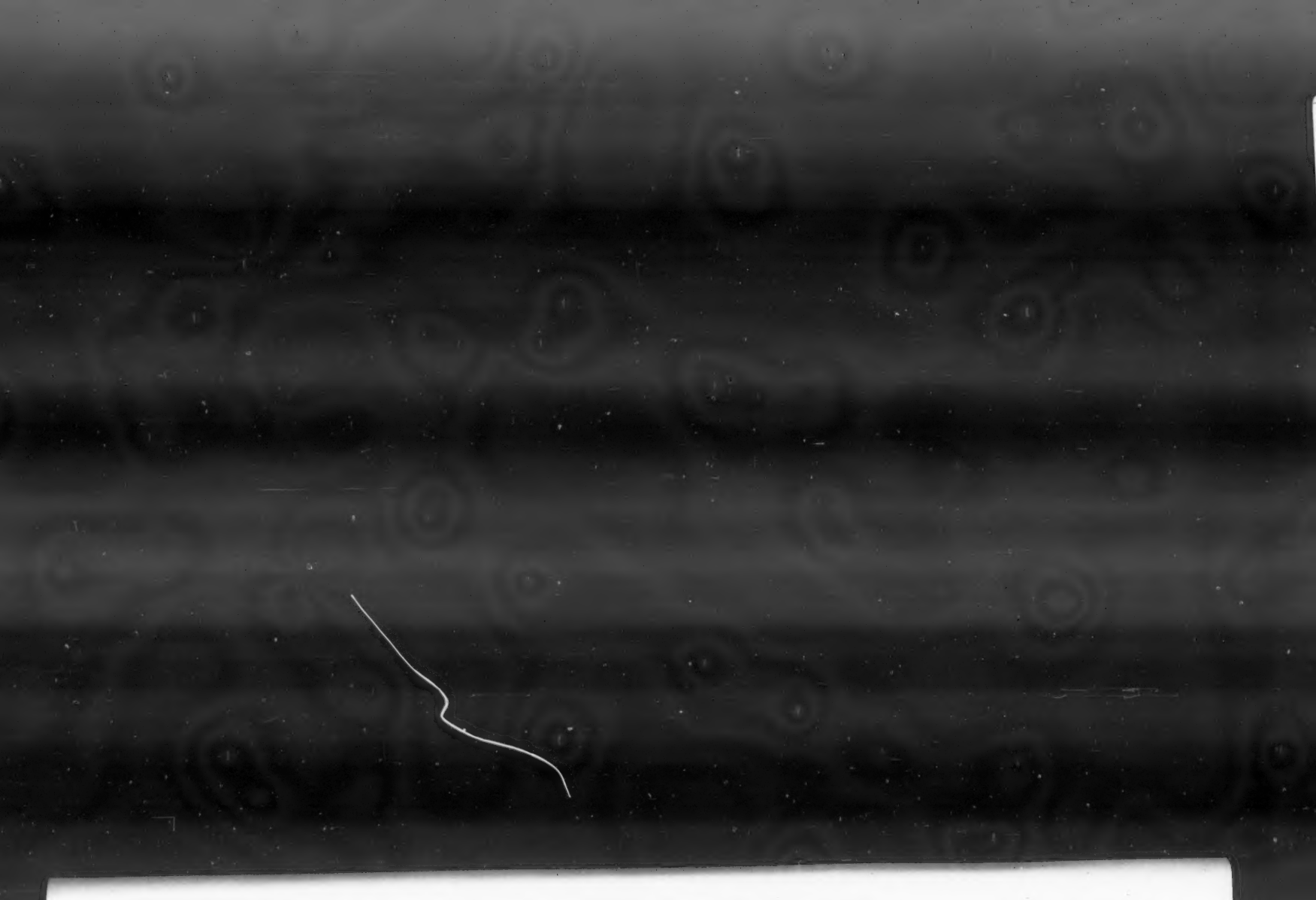
I've heard of summer camps for diabetic children. What's the advantage of such a camp?

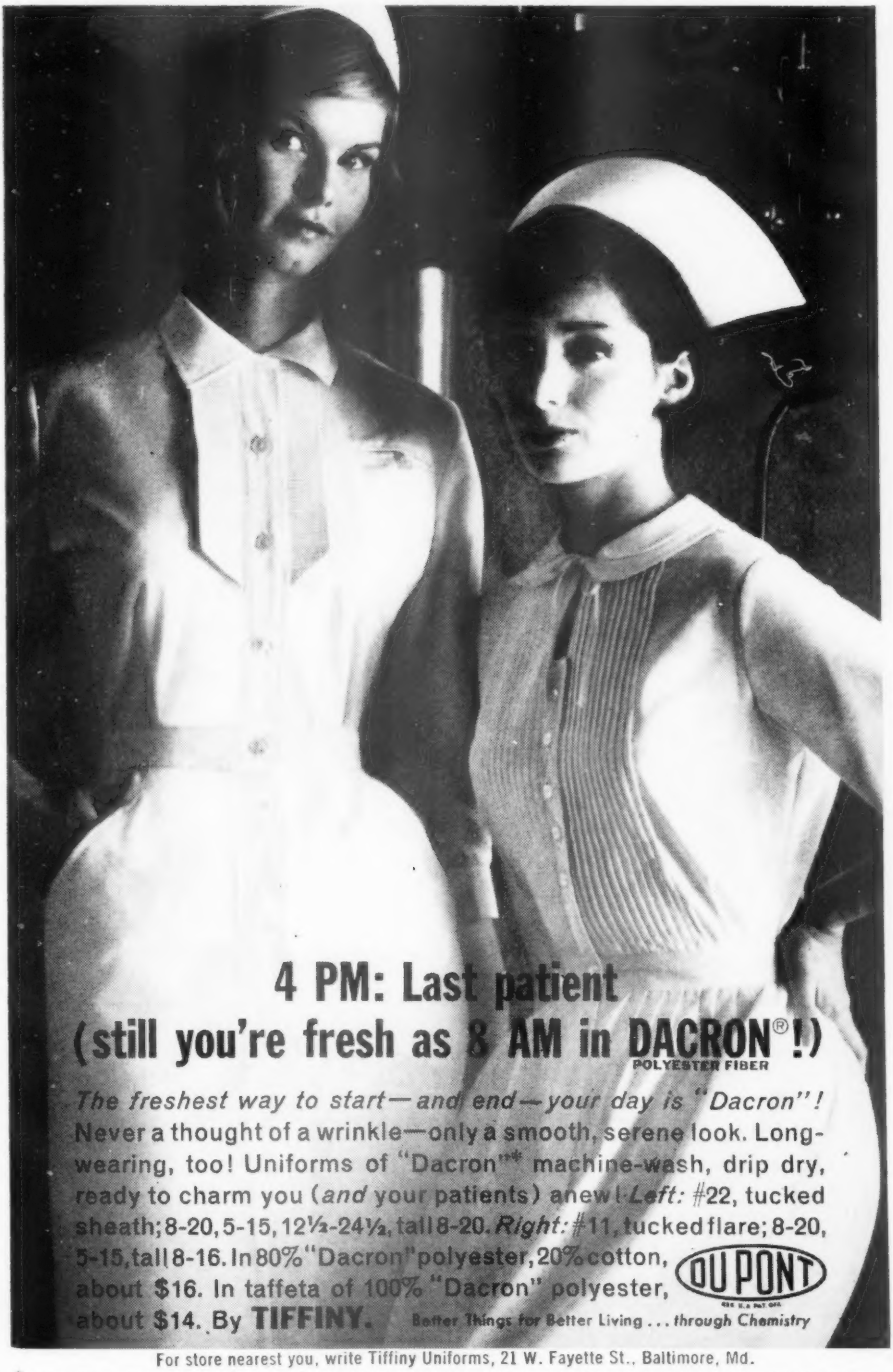
It will give *you* a rest while your child enjoys himself! As for the child: If he hasn't learned to make urine tests or to give himself injections, the camp will teach him under ideal conditions. All the children are on diets, receive insulin, and have urine tests. Activities are geared to their needs.

How can I best help my child to live with his disease?

Be kind and understanding but *not* overly sympathetic. Avoid actions that make him feel as if he's a patient or that encourage dependence on others. Urge him to take part in activities normal to his age, including vigorous play. Emphasize the control of diabetes (not the disease itself) so that he takes pride in keeping his urine relatively sugar-free.

These things will help your child to avoid "living for the disease." He can live a life free of self-pity and fear. END





For store nearest you, write Tiffiny Uniforms, 21 W. Fayette St., Baltimore, Md.

*"DACRON" IS DU PONT'S REGISTERED TRADEMARK FOR ITS POLYESTER FIBER. DU PONT MAKES FIBERS, NOT FABRICS OR UNIFORMS SHOWN.

Helping the hard of hearing

Continued from page 64

essary, you'll repeat your statement in different words.*

Second, you'll react to this evidence of the aid-wearer's handicap as matter-of-factly as you would to glasses or crutches or an artificial limb. Most hearing-aid wearers—women especially—are highly sensitive about an aid. (Some won't wear it in public.)

Third, you'll understand that wearing an aid can be a trying experience. You'll be patient, and you'll give the aid-wearer constant encouragement. Here's why he needs it:

When he turns on his aid, he leaves a comfortable, quiet world where he hears very few noises. Instantly, his aid projects near-by sounds (for example, the rattle of dishes at mealtime) into his ear at a high level. A sound that is farther away (perhaps your voice) may come through at a lower level. His mind must ignore the close-up noises and concentrate on the sound he wants to hear. This can be exhausting.

To sum up: Hearing loss has many causes. It may be temporary or permanent. Even if it's permanent, the victim usually can be helped in some degree. When you talk to your patients and friends with a hearing problem, you'll want to emphasize this point. You'll urge them to take advantage of the opportunities for hearing tests, medical treatment, and rehabilitation that are available today. END

* For other pointers, see "When Your Patient Wears a Hearing Aid," *RN*, May, 1961.

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NIVEA® *Creme* **NIVEA®** *Skin Oil*
and superfatted **BASIS® SOAP**
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*J.A.M.A. *169*:41-45 (Jan. 3) 1959. 86469

Mead Johnson Laboratories

Symbol of service in medicine

They helped bring HOPE to others

Continued from page 72

bulatory started gathering daily at a table on the ward porch to make dressings from large packs of gauze. Before long, they laughed and talked as they worked. Soon several amputees joined the group. They seemed pleased to show us how well they could work with one hand.

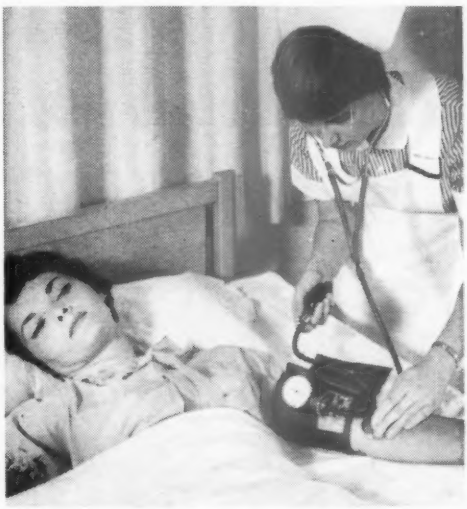
A 27-year-old paraplegic was our best salesman for the concept that patients should be encouraged to move about. Though he wasn't a neglected patient, no one had considered that his physical and mental well-being would be improved by getting him up. Soon he looked forward to leaving his bed daily for wheel-chair airings on the porch. . . .

Our final day at Makassar was a memorable one. The many friends we had made honored us with a party. One of our American nurses sang two songs for them in Indonesian. They seemed deeply touched by this evidence of our friendship and goodwill. END

YOU SAVE TIME WITH A *Tycos*® ANEROID

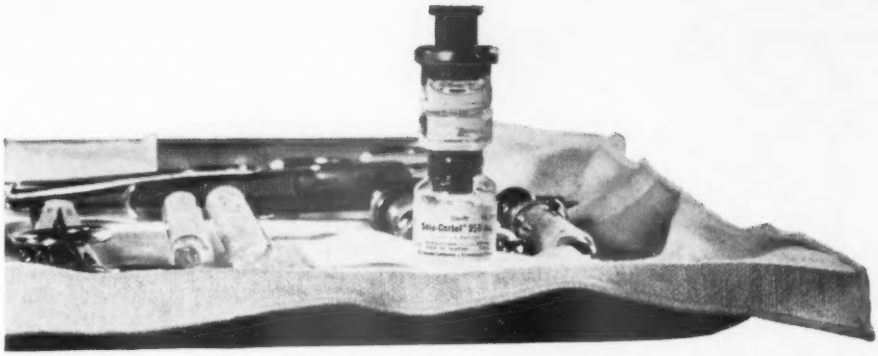
Just slip the cuff around any size adult arm . . . hook . . . and you're ready! Gage is attached to cuff, minimizing danger of accidental dropping. Attached-to-cuff model (shown), # **5090, $46.50.** Tycos Hand Model is recommended for recovery rooms—cuff can be left on patients, gage is instantly detachable. # **5098, $49.50.** Both models are available with new Velcro cuffs.

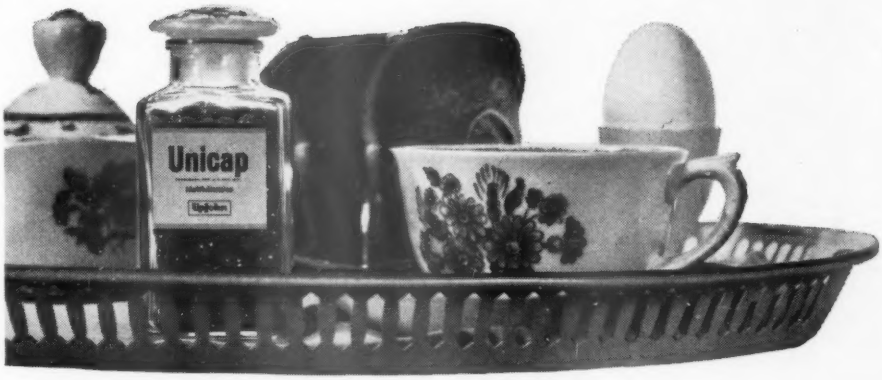
Send for free booklet on how to take blood pressure. Taylor Instrument Companies, Rochester, N. Y., and Toronto, Ontario.



ALWAYS ASK FOR A TYCOS ANEROID

***Taylor Instruments* MEAN ACCURACY FIRST**





One thing these trays have in common is not common

These two trays have in common more than the mere fact that both contain Upjohn products. The products themselves have in common an uncommon background. At Upjohn, the manufacture of the supplemental vitamin product is governed by controls as rigid as those applied to the most potent injectable steroid.

Consider just this one aspect of Unicap*: labeled potency.

Because the capsules are made under strict quality controls—several hundred safeguards, in all—you know that even after an extended shelf-life Unicap can be depended on to supply the labeled potency.

And what is true of one characteristic of Unicap is true also of its other aspects. It's no wonder, then, that so many registered nurses recommend Unicap whenever it comes to multivitamin supplementation.

*Trademark, Reg. U. S. Pat. Off.

Each capsule contains:

Vitamin A (5000 units)	1.5 mg.
Vitamin D (500 units)	12.5 mcg.
Thiamine hydrochloride	2.5 mg.
Riboflavin	2.5 mg.
Ascorbic acid	50 mg.
Nicotinamide	20 mg.
Pyridoxine hydrochloride	0.5 mg.
Calcium pantothenate	5 mg.
Vitamin B_{12} activity	2 mcg.

Upjohn 75th year

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WHAT'S NEW IN *Drugs*

Claims made here for new drug products are claims made by the manufacturers of these products and reported in this column as a service to readers. RN *itself makes no product claims.*

Microbe-killer: A sample of Japanese soil has yielded an antibiotic called colistimethate sodium that kills a variety of virulent gram-negative bacteria. Available as *Coly-Mycin Injectable*, it helps overcome chronic urinary tract infection, blood poisoning, meningitis, and respiratory infection.

It's given intramuscularly. Adding dibucaine, a local anesthetic, helps prevent pain at the injection site. Occasionally the drug causes nausea and numbness around the lips. Caution is required when giving it to patients with kidney damage. In long-term treatment, the blood count must be checked carefully.

Pressure-dropper: Phenacyl homatropinium chloride (*Trophenium*), a new ganglion-blocking agent, is being used to produce deliberate falls in blood pressure

and thus reduce the bleeding that would otherwise obscure the surgical field during certain operations (for instance, in brain and blood-vessel surgery). Blood pressure can rapidly be restored by cutting off the intravenous drip and giving a vasopressor.

Tract-calming combination: The product *Librax*, designed for relieving symptoms of gastrointestinal distress, combines the new antispasmodic-antisecretory agent clidinium bromide (*Quarzan*) with the well-known calming drug, chlordiazepoxide (*Librium*). The two counteract psychic and somatic factors of peptic ulcer, spastic colon, and similar disorders by (1) lowering the patient's response to psychic stress, (2) lessening gastric secretion, and (3) relaxing gastrointestinal-tract muscles.

Surgery aid: Hexafluorenium bromide (*Mylaxen*), a new muscle-relaxing agent, is making many surgical operations safer. It's given prior to administration of succinylcholine, another relaxant. Combining the two drugs prolongs their paralyzing action, yet reduces the danger of post-op breathing difficulty. Hexafluorenium also counteracts muscle spasm that often precedes the relaxant action of succinylcholine, thus preventing postoperative muscle soreness. —MORTON J. RODMAN, PH.D.

Convenient and Effective **ANTACID**

For Patients Away From Home

BiSoDoL Mints afford patients who work or are away from home—easily accessible yet prompt and effective relief from gastric hyperacidity. BiSoDoL Mints soothe irritated mucosa and exert prolonged diminution of gastric acidity without side effects. No risk of constipation, acid rebound or alkalosis. BiSoDoL Mints help restore the normal pH in the stomach. A most convenient, non-systemic antacid. Free from sodium ion.

COMPOSITION:
Magnesium Trisilicate, Calcium Carbonate, Magnesium Hydroxide, Peppermint.

BiSoDoL® Mints

WHITEHALL LABORATORIES, NEW YORK, N. Y.

How Dial can help curb the in hospitals

The antibacterial ingredient in Dial—a synergistic combination of hexachlorophene and trichlorocarbanilide—has long been known for its effectiveness against the skin bacteria that cause perspiration odor.

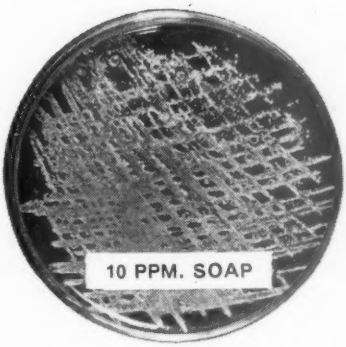
Now new and more extensive tests have established that Dial inhibits the growth of a wider range of gram-positive and gram-negative bacteria than any other leading toilet soap—including strains that are resistant to antibiotics.

Many physicians already recommend the use of Dial to their patients. Now this new evidence points up even more sharply the benefits of Dial for hospitalized patients and hospital personnel.

Dial is available in guest sizes for hospitals. Ask your hospital purchasing agent to write our laboratory at the address below for information and free samples.

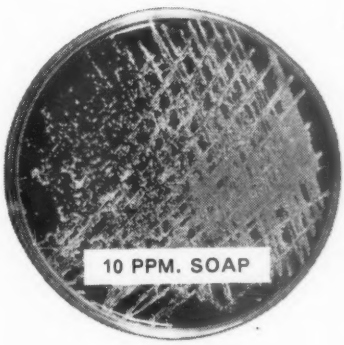
FROM THE SOAP DIVISION OF ARMOUR

Soap staph problem



In vitro tests demonstrate Dial's extraordinary effectiveness

1. Ordinary toilet soap left this heavy growth of Staphylococcus aureus



2. A widely used antiseptic soap showed little inhibition of Staphylococcus aureus

3. Dial Soap completely inhibited Staphylococcus aureus

AND COMPANY · 1355 W. 31st Street, Chicago 9, Illinois

Continued from page 28

the right leg, the doctor places one of the soniscope's two probes on each side of the suspected site. The device sends sound waves through the bone. The M.D. takes a reading that shows the speed of the waves. Next, he repeats the procedure on the left leg and compares the readings. If the first one indicates a slowdown, the bone is assumed to be broken.

To check the healing rate of a fracture, the doctor inserts the two probes into small holes that were left in the cast when it was applied. Then he turns on the sound waves, takes a reading, and compares it with previous readings. This tells him how well the bone is knitting and when the cast can be removed.

Tub/shower baths favored for post-op patients

Daily bathing in a tub or shower has no adverse effect on a clean, well-sutured surgical wound. Such bathing can be started on the second or third post-op day if the dressing has been removed (or intentionally omitted).

That's the gist of a report covering a 100-case study by Dr. Carl J. Heifetz of St. Louis. Writing in the Archives of Surgery, Dr. Heifetz points out that:

¶ A tub bath or shower cleanses the skin better than a bed bath and is more refreshing.

¶ After some help the first day or two, the patient can bathe himself, thus saving a half-hour's time for a nurse or attendant.

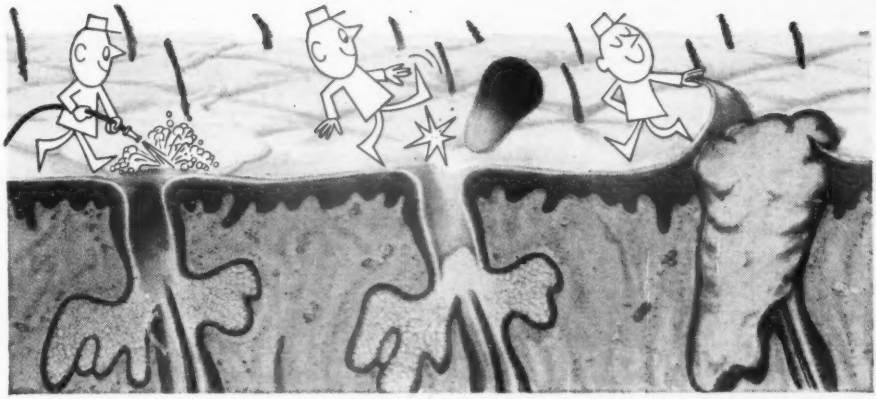
Sinusitis sufferers test do-it-yourself therapy

A new nasal spray that's used by patients themselves gave satisfactory relief in some seventy of 100 cases of sinusitis and nasal disorders, says Dr. Eduardo Pons Jr. of New York City in a report to the American College of Chest Physicians.

The spray is put up in a plastic squeeze bottle that's capped with a snug-fitting nosepiece. It contains an antibiotic-phenylephrine preparation.

To use the spray, the patient (1) squeezes the medication into one nostril while holding the nosepiece firmly in place; (2) presses a finger on the other nostril to close it; (3) simultaneously swallows with mouth closed.

This produces negative pressure. As the squeezed bottle returns to normal, it creates suction that helps to clear clogged nasal passages and nasal accessory sinuses. The patient then restores normal respiratory pressure by opening his mouth and removing his finger from the one nostril. This helps



Fostex® treats pimples·blackheads·acne while they wash

degreases the skin
helps remove blackheads
dries and peels the skin

Patients like Fostex because it's so easy to use. Instead of using soap, they simply wash acne skin with Fostex Cream or Fostex Cake 2 to 4 times daily.

Fostex contains: Sebulytic® base (unique, penetrating, surface-active combination of soapless cleansers and wetting agents*) with remarkable antiseborrheic, keratolytic and antibacterial actions . . . enhanced by micro-pulverized sulfur 2%, salicylic acid 2% and hexachlorophene 1%.

*sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate and sodium dioctyl sulfosuccinate.

Fostex Cream and Fostex Cake are interchangeable for therapeutic washing of the skin. Fostex Cream is approximately twice as drying as Fostex Cake. Supplied: Fostex Cake—bar form. Fostex Cream—4.5 oz. jars. Also used as a therapeutic shampoo in dandruff and oily scalp.

And . . . since continuous 24-hour drying and peeling of acne skin is essential, FOSTRIL (a new, flesh-tinted drying lotion) should be used once or twice daily in addition to Fostex therapeutic washings. Fostril® contains Liposec® (polyoxyethylene lauryl ether), a new, surface-active drying agent used for the first time in acne treatment. This agent, with 2% micropulverized sulfur and a zinc oxide, talc and bentonite base, provides Fostril with excellent drying properties. Fostril also contains 1% hexachlorophene.

Available: Fostril, 1½ oz. tubes. Fostril-HC (¼% hydrocortisone) 25 gm. tubes.

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. . . *news*

the medication to reach the sinuses.

He repeats the procedure four to six times in each nostril, three to four times daily.

capsules

The use of **disposable items** in hospitals is growing rapidly, reports The Modern Hospital. An example: Three years ago only one in nine hospitals used disposable needles; last year two in three used them. Most hospitals, adds the report, use disposable gloves an average of 3.3 times before discarding them. . . .

Use of **safety seat belts** in all cars, new and old, "could save at least 5,000 lives a year," says Dr. E. Vincent Askey, immediate past-president of the A.M.A. . . .

Legislation recommended by the Food and Drug Administration would authorize that agency to block the marketing of all newly developed **therapeutic devices** until their safety and effectiveness could be proved. The F.D.A. is reportedly concerned about the growing number of prosthetic and other devices being marketed for implantation in the body. . . .

Among U.S. communities with 25,000-plus population, only half have a voluntary (or semi-official)

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For FREE brochure write FASHION STUDIO . . . nurses' uniform division—Paul Jones Modiform—109 Market Place—Baltimore 2, Maryland

. . . *news*

agency that provides **home-nursing care,** says the Public Health Service. Among local health departments, less than 10 per cent provide home-nursing care on a continuing basis for all types of illness. . . .

Seven patients with **multiple sclerosis** showed "definite improvement" when treated with tolbutamide, a drug used primarily for diabetics, says a U. of Minnesota M.D. in the Journal A.M.A. Unfavorable results were noted when a high-carbohydrate diet was started. . . .

A congenital anomaly of the eye is often the first sign of **cerebral palsy,** says New York University's Dr. Arnold S. Breakey. He urges ophthalmoscopic examination of the newborn so that ocular treatment can be started early. . . .

A British-developed catheter-holder is said to simplify **urethral catheterization** and reduce contamination risk. The designers say the instrument, which resembles a thumb forceps, holds the catheter rigid during insertion and permits a "no-touch" technique. . . .

Smogtown exodus: Some 2,500 patients have left the Los Angeles area on their doctors' advice and another 7,500 have been advised to leave, a survey of local M.D.s indicates. Two-thirds of the doctors say the L.A. **air pollution** is a

major health hazard. A third say they themselves have toyed with the idea of leaving. . . .

In a mass screening of children for **heart defects,** completed recently in Chicago, health workers visited 39 schools, made 33,026 hi-fi tape recordings of heart sounds. Cardiologists found abnormalities in two children per 1,000. . . .

Former patients treated for **drug addiction** at New York City's Metropolitan Hospital can now phone in for psychologic support against the temptation to backslide. A volunteer goes to the home at once, day or night. . . .

Two patients can undergo **hemodialysis** at the same time with the twin-coil artificial kidney developed by Dr. Willem J. Kolff and associates of Cleveland. Two-way use of the unit saves time, says the doctor, is less expensive per patient, and requires less blood per patient than one-way use. . . .

How to catch a **hospital thief:** Dust several $1 bills with silver nitrate, put them in a tempting spot, then watch the staff to see whose fingers turn black (from the nitrate's reaction to perspiration). That's what a Toledo, Ohio, nursing director did. The thief? An aide, caught black-handed. (The black won't wash off.) END

Seven steps to controlling pressure sores

- Provide good nutrition
- Minimize or prevent pressure on the potential or actual area concerned
- Turn the patient regularly
- Keep the skin clean and dry
- Keep the sore as dry as possible
- Remove dead tissue
- **Apply a protective film of AEROPLAST® Dressing**

This patient care plan encourages the patient's body to rebuild damaged tissues. Application of Aeroplast Dressing protects de-nuded areas against infection and further injury by abrasion. Aeroplast is sprayed on to form a flexible plastic film over the lesion and surrounding tender skin. Although the dressing allows escape of perspiration vapors, it is impermeable to body fluids and exudates—thus protects against irritation and contamination from urine or feces.

Would you like more detailed information on treating or preventing pressure sores? If so, please write:

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Station A—Box 1, Dayton 3, Ohio
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Now! 2 appetizing foods make serum cholesterol control easier, more effective than ever!

Your Patients Can Enjoy Fine Foods With Minimum Diet Changes!

For good eating while maintaining serum cholesterol control

Leading authorities agree that where reduction of serum cholesterol levels is indicated, fat intake should not exceed ⅓ of total calories and of this, at least ⅓ should be polyunsaturated fats.

Polyunsaturated fats, such as those found in corn oil, are rich in the linoleates which are important in reducing serum cholesterol levels. This has been proven time and again in nutritional studies of hypercholesterolemia. Mazola Margarine and Mazola Corn Oil have outstanding P/S (polyunsaturate to saturate) ratios. Thus the hypercholesterolemic patient can usually enjoy the same appetizing foods as the rest of the family.

Mazola Corn Oil is unexcelled in polyunsaturates and lowest in saturates of all leading brands of vegetable oils. Mazola's P/S ratio is far higher than that of any other leading food oil. Your patient will find Mazola Corn Oil ideally suited for salad dressings and frying; also for baking wherever *liquid* shortenings are called for in the recipe.

Mazola Margarine contains *liquid* Mazola Corn Oil as a major ingredient. This corn oil is not hydrogenated, thereby preserving its rich content of linoleates. Mazola Margarine contains 2 to 3 times as much natural linoleates as any other margarine readily available in grocery stores from coast to coast. Its taste, color and handling characteristics are unexcelled.

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(All figures are in grams.)

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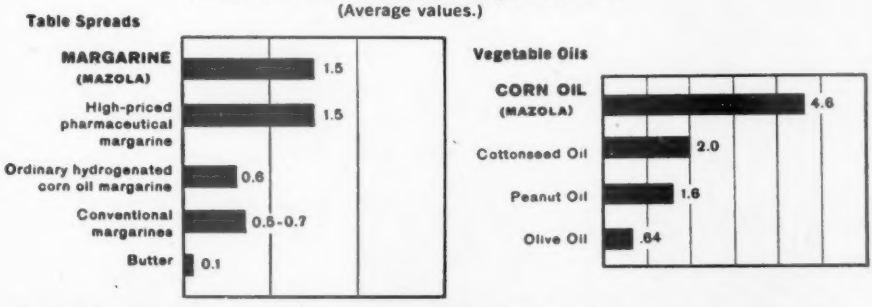
	100 grams	2 oz. (4 tbsp.)	100 grams	1 fl. oz. (2 tbsp.)
Fatty Acids				
Polyunsaturated	21	12	51	14
Monounsaturated	40	23	32	9
Saturated	14	8	11	3
Natural Sitosterols	0.5	0.3	1	0.3
Natural Tocopherols	0.08	0.045	0.08	0.020
Cholesterol	none	none	none	none
Sodium	0.9	0.5	none	none

MAZOLA MARGARINE – 410 Calories/2 oz.; Iodine Value – 96
MAZOLA CORN OIL – 250 Calories/fl. oz.; Iodine Value – 124

RATIO OF POLYUNSATURATES/SATURATES
(Average values.)



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ANESTHESIA COURSE: The Cincinnati General Hospital School of Anesthesia offers an 18 month course of training in anesthesia for registered nurses. Instruction in all type of anesthetic techniques, including endotracheal intubation, spinal block, etc. Accredited by the American Association of Nurse Anesthetists. For information write Director School of Anesthesia, Cincinnati General Hospital, Cincinnati 29, Ohio. No tuition, complete maintenance, monthly stipend during last 6 mos.

ANESTHETIST: Immediate employment opportunities, beginning salary from $5,880 to $7,180 or $6,480 to $7,980 depending on training & experience. 40-hr. wk., 4 wks. vacation, annual increments, call-in time at time & one-half, non-contributory retirement plan, plus social security & employee health plan. Call or write Miners Memorial Hospital Association, Box #61, Williamson, W. Va., Phone-BELmont 5-2424, ext. 24.

ANESTHETIST: For 209 bed general hospital in resort area, Northwestern Pennsylvania, town of 18,000. T. McFarland, Chief Anesthetist, Bradford Hospital, Bradford, Pa.

ANESTHETIST: Nurse for accredited 189-bed hospital to work with 4 anesthesiologists, infrequent night calls. Salary dependent upon qualifications & experience. Write Dr. Benjamin Cohen, Mount Sinai Hospital, 500 Blue Hills Ave., Hartford 12, Conn.

ANESTHETIST NURSES: The Albany Medical Center School for Nurse Anesthetists, associated with Albany Medical Center Dept. of Anesthesiology, offers an 18 month course of training for retistered nurses. Course begins each Sept. 1. Accredited by the AANA G.I. approval full maintenance throughout plus progressive stipend after 3 mos. For information write Miss Florence M. Maleck C.R.N.A. Albany, N. Y.

ASSISTANT DIRECTOR: For N.L.N. fully accredited diploma school of approximately 100 students. Master's degree desirable, B.S.N. mandatory, salary open, opportunity for advancement good. Write Bonnie Hughes, Director, Sparks School of Nursing, Fort Smith, Ark.

ASSISTANT DIRECTOR OF NURSING: 250 bed general hospital centrally located on Long Island. Salary open, 4 wks. vac., 8 pd. holidays, sk. lv., plus other benefits. B.S. degree & experience in Administration & supervision required. Application & details on request. Contact Personnel Director, Mercy Hospital, Rockville Centre, Long Island, N.Y.

ASSISTANT DIRECTOR OF NURSING EDUCATION: Instructor, Medical-Surgical Nursing, B.S. degree required. Opportunity to experiment in curriculum development & methods of teaching. Diploma school, 70 students, 325-bed hospital expanding to 375, new dormitory & educational building opens this fall. Salary based on education & experience, maintenance in new dormitory available. For further information write Director of Nursing Education, The Memorial Hospital, Danville, Va.

ASSISTANT DIRECTOR OF SCHOOL: Student body of 75 in college town of 45,000, easily accessible to Chicago, St. Louis and Kansas City. Baccalaureate degree & experience desirable. Stimulating & vital situation. Apply St. Mary's Hospital, Quincy, Ill., Salary $6,000 to $7,200.

ASSISTANT NURSING INSTRUCTOR-OBSTETRIC NURSING: Newly created position, Formal & Clinical Teaching, NLN full accreditation, 1 class yearly or approximately 40 students. B. S. degree & teaching experience required. Liberal personnel policies, salary based upon background, no nursing service responsibilities, 500 bed hospital, direct transportation to NYC in 35 minutes. Write to Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

ASSISTANT. SUPERVISOR,. EVENINGS AND/OR NIGHTS: Full or part time, 400 bed private general hospital with school of nursing. Applicants should be in excellent health between approximate ages of 26-45. B.S. degree in nursing or equivalent, with previous head nurse or supervisory experience required. Liberal salary range and employee benefits. Excellent working conditions in one of midwest's foremost institutions, centrally located in city and convenient to outstanding residential and shopping facilities. Contact Personnel Director, Milwaukee Hospital, 2200 West Kilbourn Ave., Milwaukee 3, Wis.

CALIFORNIA OPPORTUNITY: Surgery & General Duty R.N.'s near coast in Southern Calif., 96 bed J.C.A.H. approved Community Hosp. Please contact Mrs. Viola Anderson, Director of Nursing Service, Torrance Memorial Hosp. 1425 Engracia Ave., Torrance, Calif.

CALIF. REGISTERED NURSES: Needed for staff duty in JCAH, 428-bed hospital. Good benefits & salary. Personnel Director, Hospital Good Samaritan, 1212 Shatto St., Los Angeles 17, Calif.

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CLINICAL INSTRUCTORS: Medical Surgical nursing, Obstetrics & Psychiatry. 525 bed hospital, 170 students, degree & experience required, salary commensurate with qualifications. Apply Director of Nursing, Missouri Baptist Hospital, 919 North Taylor Ave., St. Louis 8, Mo.

CLINICAL INSTRUCTORS: Obstetrics, Pediatrics & Medical nursing. 450-bed modern general hospital with separate building for obstetrics. Diploma program with 200 students in NLN fully accredited school. B.S. degree required & experience desired. Liberal personnel policies, located in Northwest, near skiing & ocean. Apply director, School of Nursing, Good Samaritan Hospital, Portland 10, Ore.

DIRECTOR OF NURSES II, PSYCHIATRIC: Charge of all phases of nursing service at Eastern Shore Hospital, starting salary $586 per mo. Apply Commissioner of Personnel, 301 W. Preston St., Baltimore 1, Md.

DIRECTOR OF NURSING: 28 bed, modern proprietary hospital 66 miles from NYC in resort area. BA degree desirable. Supervisory experience required. Attractive fringe benefits. Salary open. Contact Administrator, Doctors Sunnyside Hospital, Port Jervis, N.Y.

DIRECTOR OF NURSING SERVICE: To direct nursing service in modern progressive 200 bed hosp., fully accredited in pleasant community free from fog, smog & crowded industrial areas. State capital & growing medical center of Wyo.,—50,000 pop., excellent personnel policies, 40 hr. wk., vac., sk. lv., 7 pd. holidays, new nurse residence only $43 room & board, salary open based on experience & background. Contact Administrator, Memorial Hospital, Cheyenne, Wyo.

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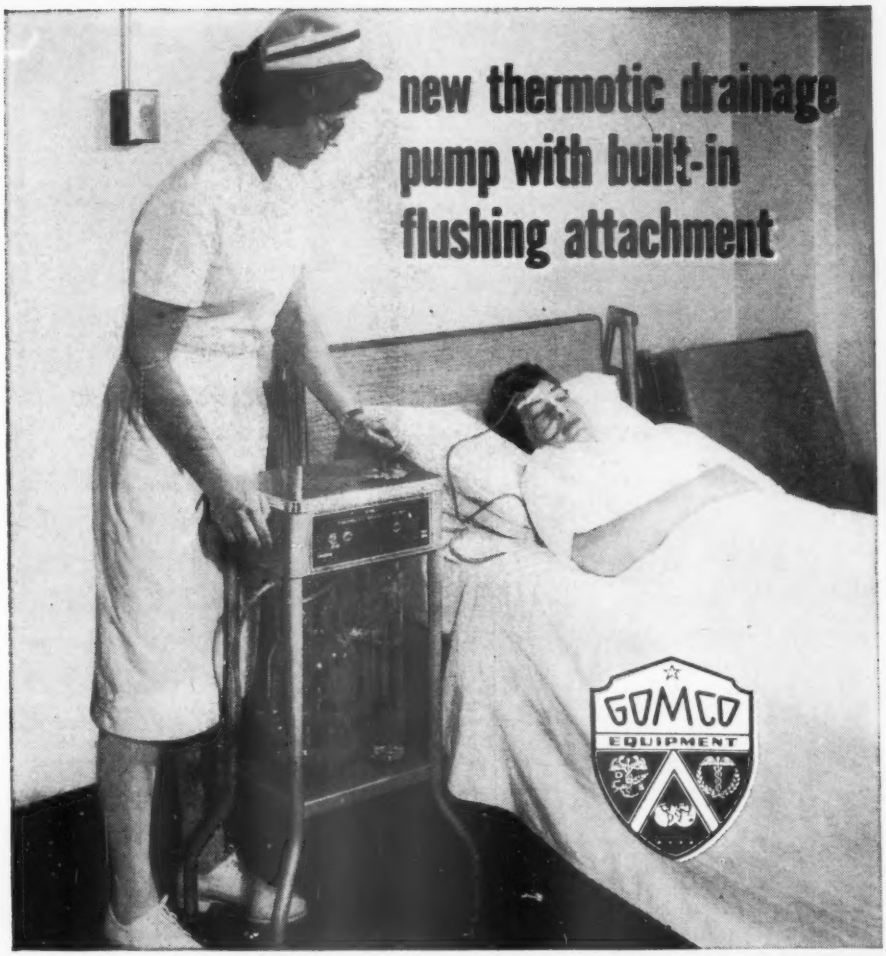
DIRECTOR, NURSING EDUCATION: For fully accredited 191 bed hospital expanding to 250 beds. Master's degree desired, will consider Bachelor's with experience. School fully ac-



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DIRECTOR, SCHOOL OF NURSING: To head a school for a 220 bed hospital. New modern classrooms, in central South Carolina. Salary open depending on qualifications and experience. Write R. G. Roach, Director, Orangeburg Regional Hospital, Orangeburg, S. C.

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FORT MYERS, FLA: "The City of Palms", Nation's fastest growing area. Yearly average temperature 72°. R.N.'s & L.P.N.'s, 40-hr. wk., good pay & extra benefits. Write Director of Nursing, Lee Memorial Hospital.

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GENERAL DUTY NURSES: Opportunities for both men & women in a network of 10 general hospitals located in southern West Virginia, eastern Kentucky., & southwestern Virginia. 40 hr wk., 4 wks. vacation, 7 pd. holidays, Employee Health plan, non-contributory retirement plan, plus social security, salary at the rate of $4440 or $4860 depending upon experience. Write or call, Personnel Officer, Miners Memorial Hospital Assn., Field Office, Box 61, Williamson, W. Va., Telephone BELmont 5-2424.

GENERAL DUTY RN: For 33 bed general, medical, and surgical hospital located in Bunnell, Fla. Hospital is 5 yrs. old. Pleasant working conditions, pd. vacations, holidays, pd. insurance benefits, social security and other fringe benefits. Salary range depending upon qualifications of the applicant. Contact Homer R. Bentley, Administrator, Flagler Clinic & Hospital, Inc., 207-9 Bacher St., Bunnell, Fla.

GENERAL DUTY & PSYCHIATRIC NURSES: $431-$471 per mo., new 500 bed general hospital opening this yr., plus large psychiatric division on grounds in suburban Detroit, good personnel policies, including up to 15 days vacation and 11 pd. holidays. Apply Director of Nursing (either General or Psychiatric) Wayne County General Hospital, Eloise, Mich.

GENERAL DUTY NURSES: For 72 bed hospital located in college town in mountainous portion of Colo. Salary $350 per mo. with periodic increases, fringe benefits including meals, sk. lv., vacation, etc. Contact Superintendent, Alamosa Community Hospital, Alamosa, Colo.

GENERAL DUTY NURSES: 84 bed hospital, finest equipment, 40 hr. wk., very liberal personnel policies, pleasant working environment, rotating shifts, salary range $337.99 to $457.59 mo., $20 evening and night differential. Atomic Energy Project, not civil service. Write Director of Nurses, Los Alamos Medical Center, Los Alamos, N.M.

GENERAL DUTY NURSES: 135 bed hospital on San Francisco Bay. Rooms available. Opportunity for advanced education in the area. Salary range—monthly—$345 to $390. $20 shift differential, $10 added for experience OB and OR. Director of Nurses, Alameda Hospital, 2070 Clinton Ave., Alameda, Calif.

GENERAL DUTY REGISTERED NURSES: Small general hospital with informal & congenial atmosphere. Shift premium. Pd. vacation, holidays & sk. lv., Blue Cross avail., convenient transportation, reasonable rentals in neighborhood. Apply Director of Nurses, Forkosh Memorial Hospital, 2544 W. Montrose Ave., Chicago 18, Ill., Corneelia 7-2200

GENERAL DUTY STAFF NURSES: Vacancies on all services due to completion of new wing which has increased bed capacity above 400. Private general hospital with 125 student school of nursing, 3 yr. diploma course. University nearby for advanced study. 40 hr. wk. Excellent salary and liberal benefit program, including noncontributory pension plan, in outstanding midwestern institution. Centrally located in the city and convenient to residential and shopping facilities. Living accommodations adjacent to the hospital available at nominal rent. Contract Personnel Director, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wis.

GENERAL STAFF NURSES: Positions on all services with opportunity for professional advancement in 400 bed hosp. Rotating or permanent eve. & night assignments, 40 hr. wk., retirement pension plan, Blue Cross, social security, convenient transportation to educational & cultural facilities, good residential area. Apply Director of Nursing, West Suburban Hospital, Oak Park, Ill.

GENERAL STAFF NURSES: Immediate openings on 3-11 & 11-7 shifts in 92-bed general hospital near San Francisco. Starting salary $363 plus $20 for 3-11 & 11-7 shifts. Liberal fringe benefits. Rooms available in nurses' residence at $20 per mo. Apply Director of Nursing Service, Pittsburg, Community Hospital, 550 School St., Pittsburg, Calif.

GRADUATE NURSE: Well qualified to direct a brand new modern pediatric unit of 36 patients. Will also teach pediatric nursing to small good student body, pleasant cooperative staff. Master's degree preferred, baccalaureate degree acceptable. Apply Personnel Office, New Rochelle Hospital, New Rochelle, New York.

GRADUATE NURSES: Betty Hartwig is the name. That is Betty Hartwig is my name and this time it goes first. I've been putting my name last just too darn long, Miss Hamil, my boss and Director of Nurses here at Los Angeles County General Hospital, brought up the matter. "Betty", she said, "why not put your name first for a change?" That's the way Miss Hamil is. Well, being the way I am, I said "no" and that settled it because that's the way things are here. But every once in a while Miss Hamil brought up the matter and so this time as a special favor to her, I did it. As a matter of fact, as you can see, I did it and did it—Betty Hartwig, Betty Hartwig, Betty Hartwig, Betty Hartwig, Betty Hartwig and now that its done I feel fine. I guess everyone likes to see their name in print. I guess Miss Hamil knows that. She sure is a terrific Director of Nurses. She can be your Director too. Write me at the Los Angeles County General Hospital, 1200 N. State St., Los Angeles 33, Calif. I'll tell you how!

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main building has created attractive positions for staff nurses in medical, surg., obstetric and pediatric divisions of 450 bed non-sectarian acute general hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Apartments available in immediate neighborhood. Apply Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 E. 105th St., Cleveland 6, Ohio.

GRADUATE NURSES: For general duty, 75 bed general hospital, new air-conditioned, with modern equipment. Beginning salary $275 a mo. with differential for eve. and night duty and operating room nursing. Good personnel policies, 5 day, 40 hr. wk, vacation, pd. sick lv., holiday time. Located in beautiful central Florida. Apply Director of Nurses, Seminole Memorial Hospital, Sanford, Fla.

GRADUATE STAFF NURSES: Opportunities for men and women on all services including Psychiatry and Operating room. Well planned orientation and in-service training programs, tuition free courses at Western Reserve University, low cost housing in nurses residence. Write for University Hospitals booklet "New Horizons in Nursing". Salary range staff nurses, $355 to $390, head nurses, $388 to $453, many fringe benefits. For more information write to Director of Nursing Service, University Hospitals of Cleveland, University Circle, Cleveland 6, Ohio.

GRADUATES: Mercy College of Anesthesiology offers an 18 mo. AANA approved course to graduates of accredited schools of nursing. Write: Director, Anesthesia Dept., Mount Carmel Mercy Hospital, Detroit 35, Mich.

HEAD NURSE FOR GENERAL RESEARCH & STUDY UNIT: In 21 bed medical area. Liberal personnel policies & $50 eve.-night differential, salary commensurate with experience. Write Director of Nursing Service, The John Hopkins Hospital, Baltimore 5, Md.

HEAD NURSES: Medical, surgical & orthopedic departments, evening & night shifts, 450 bed general hospital, liberal personnel policies. Contact Director of Nursing, Good Samaritan Hospital, Portland 10, Ore.

HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy & old-fashioned warm care of patients with cancer & allied diseases. Teaching & research center offers valuable experience, adequate staff of top nurses maintained. University affiliated in-service education; access all NYC educational programs, good basic preparation required; learn surgical-medical-radiation therapy. Not a chronic disease hospital. Staff nurses, day $379-$469 mo., evening $434-$524, night $423-$513, 4 wk. vacation, 1½ pay for overtime, Blue Cross pd., uniforms laundered, minimum rotation, furnished apartments avail. through Housing Agent. New 20 story apartment house overlooking East River opens June 1962. Suture Nurses: base salary plus ½ pay for on-call. Director of Nursing, memorial Hospital, Memorial Sloan Kettering Cancer Center, 444 E 68th St., New York 21, N. Y.

INSTRUCTOR: Immediate & urgent need for Instructor of Maternal & Child Health Nursing in a 3-yr. diploma program, 60 students, N.L.N. accredited, 184 bed hospital. Bachelor's degree & experience in obstetrical nursing required. Apply to Director of Nurses, Helene Fuld Hospital, Trenton, N.J.

INSTRUCTOR: Psychiatric in a fully accredited 225 bed private psychiatric teaching hos-

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INSTRUCTOR OF NURSES, PSYCHIATRIC: Varied, challenging career opportunity in beautiful Maryland. Starting Salary $420 per mo. Apply Commissioner of Personnel, 301 W. Preston St., Baltimore 1, Md.

MEDICAL-SURGICAL CLINICAL INSTRUCTOR: In a unique program. N. Y. City area, 3-5 yrs. experience, B.S. required. Box #PH-2, c/o RN Magazine, Oradell, N. J.

MEDICAL AND SURGICAL CLINICAL INSTRUCTOR: Diploma school affiliated with Community College. B.S. degree and teaching experience required. Good personnel policies. JCAH accredited 210 bed general hospital. Apply Director of Nursing, White Plains Hospital, White Plains, N. Y., Telephone WH 9-4500, Ext. 255.

MEDICAL-SURGICAL SUPERVISOR: Administrative. 500 bed voluntary hospital. Degree & satisfactory experience required. Salary dependent on education & experience, liberal personnel policies, direct transportation to NYC in 35 minutes. Write to Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

NURSE ANESTHETIST: Registered nurse, experience in supervision & anesthesiology, to work as anesthetist, relieving director of nurses, assisting with nurses aide training program. Salary range $464-$581 per mo. Starting salary $519 if experienced in anesthesiology. Living accommodations for single person at nominal charge, modern, well equipped hosp. in rural area, 15 working days vacation annually, sk. lv., retirement system, including Social Security. Contact William A. Winn., M.D., Tulare-Kings Counties Hosp., Springville, Calif.

NURSE ANESTHETIST: 40-bed hospital, college town, resort area. Excellent personnel policy, retirement plans. Share call with another nurse anesthetist. Prefer individual who would be interested in learning Hospital Administration. Contact R. Houfek, Administrator, Ripon Municipal Hosp., Ripon, Wis.

NURSE ANESTHETIST: For 100 bed general hospital to complete staff of 3. New modern, air-conditioned hospital located in Midwest University town, salary open, dependent on qualifications & experience. Write Jack Edmundson, Administrator, Doctors Hospital, Carbondale, Ill.

NURSES: Wanted immediately, 2 alert & ambitious registered nurses who are looking for opportunities to integrate & broaden their experience in all fields of nursing. Salary $310-$360 per mo., 40 hr. wk., generous sk. lv., 8 holidays & 2-3 wks. vacation all with pay yearly. Also other liberal personnel policies. Write Supt. Beaver County Hospital, 41 Center St., W., Milford, Utah

NURSES: For new 75 bed general non-profit hospital. Resort area. Contact Administrator, South Coast Community Hospittal, South Laguna, Calif. HYatt 4-8501.

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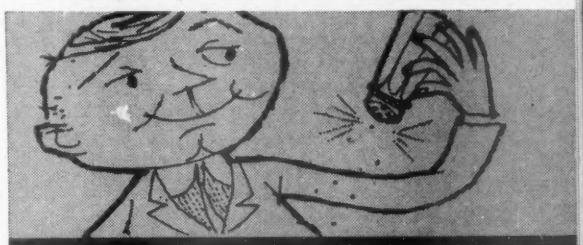

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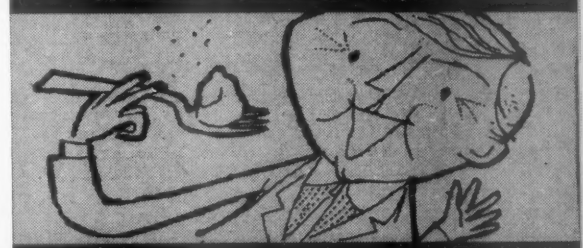

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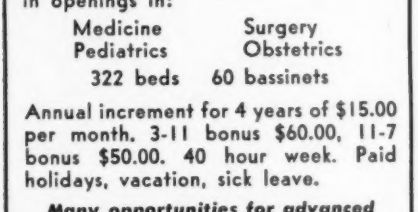

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climate. Salary range $300-$400 mo. for 44 hr. duty. Liberal personnel policies. Sick lv. plan with 6 holidays per yr. Also we pay differential of $10 extra PMs. If interested please contact Administrator, Clovis Memorial Hospital, Clovis, N. Mex.

NURSES: General duty, 236 bed hospital, 30 mi. from NYC. Apartment-style residence. Good salaries, free benefits and pension plan. Modern Hospital. Write director of Nursing, Morristown Memorial Hospital, Morristown, N. J.

NURSES, REGISTERED: Qualified staff nurses for several areas including progressive care units. Excellent benefits include shift and weekend bonus. Beautiful suburban area, North Jersey, 35 min. from NYC. Low cost housing, inexpensive meals and laundry, pension plan, etc. All nursing areas air-cond. Apply Personnel or Director of Nursing, Mountainside Hospital, Montclair, N. J.

NURSES STAFF: Opportunities in all areas in modern 200 bed hospital 45 minutes from New York City. Apartment type nurse's residence situated on 64 acres in the heart of historic Sleepy Hollow Country. Progressive personnel policies, rotating shifts-bonus for evenings and nights. Apply Director of Nursing, Phelps Memorial Hospital, No. Tarrytown, N. Y.

NURSING INSTRUCTOR-OBSTETRICAL NURSING: Newly created position, formal & clinical teaching, NLN full accreditation, 1 class yearly of approximately 40 students. B.S. degree & teaching experience required, liberal personnel policies, salary based upon background, no nursing service responsibilities, 500 bed hospital, direct transportation to NYC in 35 minutes. Write to Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

OBSTETRICAL SUPERVISOR: Responsible for supervision of 76 bed unit—over 3600 births—year & teaching program for nursing students. Degree &/or satisfactory experience. Salary commensurate with qualifications. Liberal personnel policies. Direct transportation to NYC in 35 minutes. Write to Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

OR AND GENERAL DUTY NURSES: New 65 bed hospital, College town, to be opened early 1961. Contact Director of Nurses, Hillcrest General Hospital, Silver City, N. M.

OR & STAFF NURSING: Active 100 bed children's medical center. University affiliation. Good personnel policies. Apply Director of Nursing, St. Christopher's Hospital for Children, 2600 N. Lawrence St., Philadelphia 33, Pa. Telephone GA 6-5600.

OPERATING ROOM NURSE: Modern air-conditioned 53 bed hospital, small town, 35 miles from New York City, fringe benefits, pension plan, Social Security, Blue Cross, attractive nurses' residence. Write to Tuxedo Memorial Hospital, Tuxedo Park, N. Y.

OPERATING ROOM NURSE: Wanted for 272-bed general hospital. Must have OR experience. Complete, new, modern operating area consisting of 6 operating rooms, air-conditioned with the latest modern equipment, plus 14-bed recovery room & central sterilizing. Excellent salary with one of the finest nurses' personnel policies. Beautiful nurses' home with all private rooms nicely furnished. If interested, write or apply Dover General Hospital, Dover, N. J., c/o C. T. Barker, Director.

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STAFF NURSES: For 6 bed Children's Metabolic Study Unit. Experience in pediatric nursing, aptitude for research, liberal personnel policies, salary range $3682-$4326; $600 annual differential for eve.-night. Write Director of Nursing Service, The Johns Hopkins

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STAFF NURSES: For modern, large tuberculosis hospital in suburban Cleveland. Starting salary $370 with semi-annual increments. Extra for night and relief duty, non-rotating shifts, opportunities for advancement, pd. vacation and holidays, liberal sk. lv. cummulative to 90 days. Progressive retirement plan with employer matching contributions includes disability and survivor benefits. Attractive, completely furnished 2-bedroom homes available at very low rent including utilities for two single nurses or married nurses. Write Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

STAFF NURSES: 245 bed general hospital fully accredited, 40 hr. wk., 2 wks. vacation, 6 pd. holidays, 12 days sk. lv. annually, good recreational area. Starting rate $330. Apply Director of Nursing Service, Memorial Hospital, Casper, Wyo.

STAFF NURSES: For JCAH accredited 210 general hospital with diploma school of nursing, 35 miles from New York City. Rotating staff, salary range $335 to $375 per mo; $50 differential for 3-11 duty, $40 differential for 11-7. Liberal personnel policies including generous sk. time and vacation allowance. Pleasant living facilities provided at $30 per mo. Call or write Director of nursing, White Plains Hospital, White Plains, N. Y. Telephone WHite Plains 9-4500.

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SUPERVISOR: Administrative for 3-11 ; 11-7 shifts in a 226 bed J.C.A.H. accredited hospital. Will have 327 beds after remodeling. Must be eligible for reg. in Calif. Degree desired plus progressive experience. L.A.-L.B. good pay area. See A.J.N. May, 1961, page 89. Increases at 6 mo., 1-2-3 yrs. Pd. vacation, 7 holidays, sk. lv. soc. sec., Blue Cross avail. If looking for a good position plus ideal climate, apply to Dir. of Nsg., Serv., Long Beach Community Hosp. 1720 Termino Ave., Long Beach 4, Calif.

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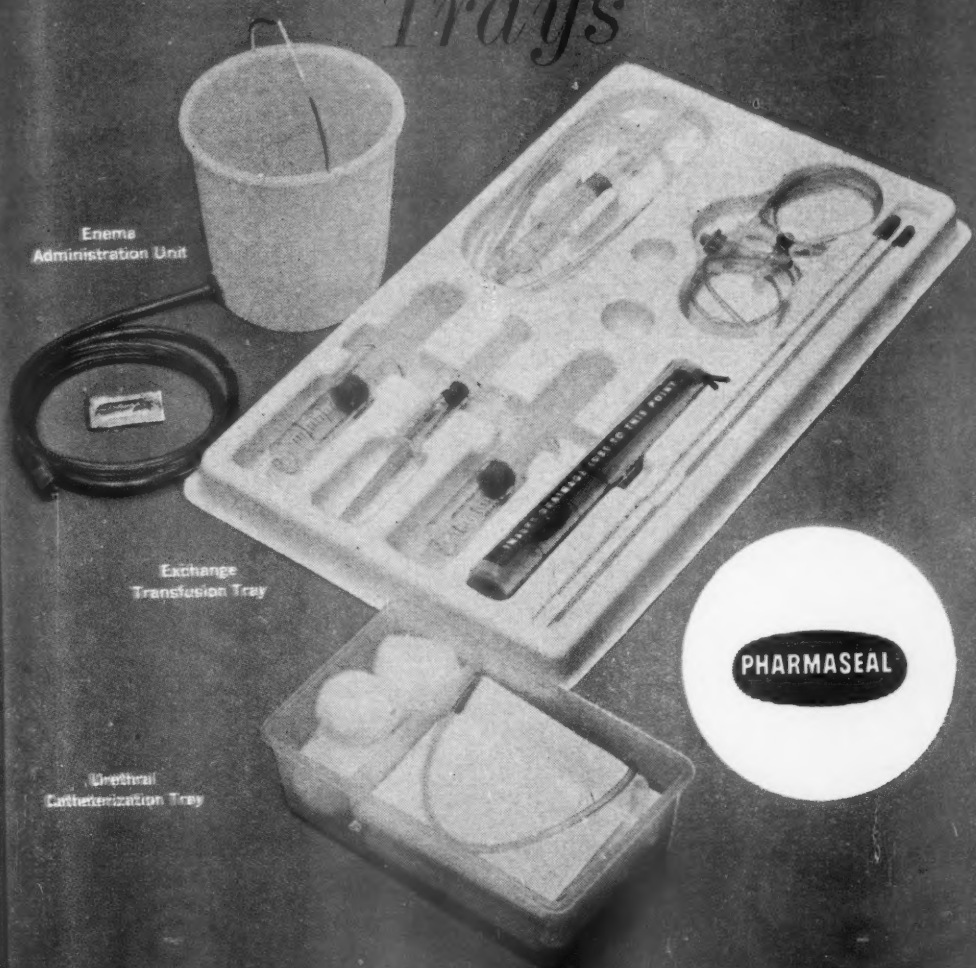

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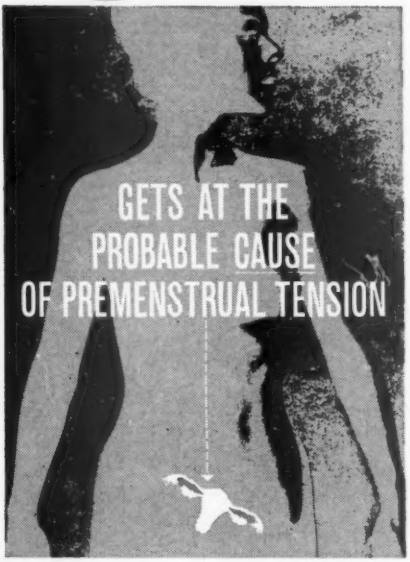

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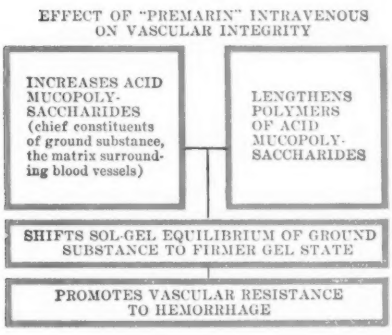

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AYERST LABORATORIES
New York, N. Y. ■ Montreal, Canada

*Schiff, M., and Burn, H. F.: A.M.A. Arch. Otolaryng. 73:43 (Jan.) 1961.

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